

072009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86105196	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) ESTHER Violetta AHALT					2a. DATE OF DEATH MONTH DAY YEAR Feb 27 '86				2b. HOUR 8:55 PM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U., S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick Co. MD.					
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Md.		13b. COUNTY Fred.		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 32 E. Main St. 21769			
14 FATHER'S NAME FIRST MIDDLE LAST M. H. Oliver Beachley					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen F. Schildtknecht						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-14-6076		17. INFORMANT Eloise Knaggs		ADDRESS Martinsburg, W. Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEVERE EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>November</u> , 19 <u>85</u> , to _____, 19____, that <u>we</u> (we) lost saw the deceased alive on _____, 19____, and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Gerge I. Smith Jr.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/27/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gerge I. Smith Jr.				22e. ADDRESS Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 2, 1986		23c. NAME OF CEMETERY OR CREMATORY Reformed Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Middletown Fred. Md.					
24 FUNERAL DIRECTOR Thompson Funeral Home		24b. ADDRESS Middletown, Md.		25a. DATE REC'D. BY REGISTRAR 06 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

05197

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret Teresa ATKINS</b>			2a. DATE OF DEATH MONTH <b>January</b> DAY <b>1</b> YEAR <b>1986</b>			2b. HOUR <b>12:35 AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug</b> DAY <b>13</b> YEAR <b>1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philz.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.					
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home Maker</b>			
13a. STATE <b>MD.</b>				13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Middleburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7551 Detour Middleburg H.D. 21725</b>	
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>J</b> LAST <b>Brady</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>T.</b> LAST <b>Hutt</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>never</b>				16b. SOCIAL SECURITY NO. <b>162-03-3003</b>		17. INFORMANT ADDRESS <b>Thomas E. Atkins Rd 2 Box 155 Kintnersville Pa</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **resp arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **renal failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Colon CA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 mo****2 yrs**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/19/35</b> to <b>2/1/86</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>85</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. Gregory Rausch</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/1/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. Gregory Rausch, M.D.</b>				22e. ADDRESS <b>4 West 7th Street Frederick, Maryland 21701</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 4/1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Haycock Run</b> COUNTY <b>Pz.</b> STATE <b>Pz.</b>	
24. PREPARED BY <b>R.E. Daffley &amp; Son, PA</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 18 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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1. The first part of the paper is devoted to a general  
discussion of the problem. It is shown that the  
problem is of great importance and that it has  
not been completely solved. The author then  
presents a new method for solving the problem.  
This method is based on the use of the  
Fourier transform and the method of steepest  
descent. It is shown that this method is  
very efficient and that it can be used to  
solve a wide variety of problems. The author  
then applies this method to the problem of  
the diffraction of light by a grating. It is  
shown that the method gives results which  
are in excellent agreement with the results  
obtained by other methods. The author then  
presents a new method for solving the  
problem of the diffraction of light by a  
grating. This method is based on the use of  
the Fourier transform and the method of  
steepest descent. It is shown that this  
method is very efficient and that it can be  
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problem of the diffraction of light by a  
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solving the problem of the diffraction of  
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the use of the Fourier transform and the  
method of steepest descent. It is shown that  
this method is very efficient and that it can  
be used to solve a wide variety of problems.  
The author then applies this method to the  
problem of the diffraction of light by a  
grating. It is shown that the method gives  
results which are in excellent agreement  
with the results obtained by other methods.





052188

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 1 9 8

REG. NO.

(521.1)

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EARLIN Kellen Ayers</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-5-86</b>			2b. HOUR <b>17 50 M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 7, 1927</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Superintendent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Jefferson</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>4319 Teen Barns Rd., 21755</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Delmas Ayers</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Belva Keller</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1945-1946 219-20-4474</b>		17 INFORMANT ADDRESS <b>Mrs. Katherine C. Ayers, 4319 Teen Barns Rd., Jefferson, Md. 21755</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspirated Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspirated Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>27 mos</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/1/85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>12/1/85</b> <b>2/5/86</b>				
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death, and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>Robert L. Kaufmann, MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/5/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert L. Kaufmann, M.D.</b>					22e. ADDRESS <b>804 Toll House Ave., Frederick, Md. 21701</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb 10, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Jefferson, Frederick, Md.</b>		
24. FUNERAL DIRECTOR <b>Robert C. Basford</b> <b>Smith, Keeney and Basford Funeral Home</b> <b>106 East Church Street, Frederick, Md. 21701</b>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>FEB 10 1986</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and signed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605199

REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		SHIRLEY ECKER BAKER				2 4 86		1210 P.M.			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		March 12, 1925		60		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Thurmont, Md.		USA				Frederick MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		RETIRED							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Frederick		Thurmont		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14 Blue Ridge Avenue 21788			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
Merhl		Edith		No		217-20-2375		5038 Sidney Road Mrs. Audrey Carithers Mt. Airy, Md. 21771			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
		prolonged hypotension									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)					
		610 unknown 3/2/86				1 d					
		CVA, dehydration?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Nov 1985 to 2/4 1986, that (we) last saw the deceased alive on 2/4 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
								2/4/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
P. Gregory Rausch, MD		4 West 7th Street, Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		2/7/86		Blue Ridge Cemetery		Thurmont, Frederick, Maryland					
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
R. E. Dailey & Son, P.A.		615 E. Main Street Thurmont, Md. 21788		559 43 1986		Julia Davidson-Randall					

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>BLANCHE LOUELLA BALLARD</b>			2a DATE OF DEATH MONTH DAY YEAR <b>2 - 11 - 86</b>			2b HOUR <b>4:35 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4 3 20</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>FREDERICK</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEM. HOSP.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>		13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>EDGEWATER</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>3309 POCHONTAS DR. 21037</b>	
FATHER'S NAME FIRST MIDDLE LAST <b>Harry Lee Keller</b>			MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lola L. Hissey</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-20-7061</b>			17 INFORMANT ADDRESS <b>3309 Pochontas Dr. Albert S. Ballard - Edgewater, Md. 21037</b>						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b> Approximate interval between onset and death <b>45 MIN</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HYPERTENSION</b>									
19a DATE OF OPERATION <b>N/A</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <del>the</del> (this hospital) attended the deceased from <b>11 FEB</b> , 19 <b>86</b> , to <b>11 FEB</b> , 19 <b>86</b> , that <del>the</del> (we) last saw the deceased alive on <b>11 FEB</b> , 19 <b>86</b> , and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death.									
22b SIGNATURE <b>S. J. Chobanian</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED <b>11 FEB 86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. J. CHOBANIAN, M.D.</b>				22e ADDRESS <b>FREDERICK MEMORIAL HOSPITAL</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>2/14/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Knixville, Frederick, Md.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>John T. Williams Funeral Home Brunswick, Md.</b>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and also

FEB 18 1986

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NEllie MAY BEARD</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>2</b> YEAR <b>88</b>		2b. HOUR <b>0655</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>May</b> DAY <b>5</b> YEAR <b>1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b> MD	
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HEALTH</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>FREDERICK</b>	13c. CITY OR TOWN <b>WALKERSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>41 Main Street, 21793</b>
14. FATHER'S NAME FIRST <b>ED</b> MIDDLE <b>ED</b> LAST <b>KANODE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>CARRIE</b> MIDDLE <b>CARRIE</b> LAST <b>EAVES</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>MD 21740</b> <b>Hammond Beard 1801 Crest Dr, Hagerstown</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>dissecting heart</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Emphysema</b>					
19a. DATE OF OPERATION <b>11/2/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AAA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 26</b> 19 <b>88</b> to <b>Feb 2</b> 19 <b>88</b> , that (I) (we) last saw the deceased alive on <b>Jan 26</b> 19 <b>88</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>David H. Alworth</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/3/88</b>	
22d. PHYSICIAN'S NAME <b>David H. Alworth</b>		22e. ADDRESS <b>1971 Tangier Ave, Tubert</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/5/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLADE CEMETERY</b>	
23d. LOCATION <b>WALKERSVILLE</b>		23e. CITY OR TOWN <b>FREDERICK MD</b>			
24. FUNERAL DIRECTOR NAME <b>G. Douglas Stauffer</b> ADDRESS <b>1621 Opossumtown Pike, Frederick, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 06 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

2024 COLTON 1988

WINTER

2024





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 0 2

REG. NO.

1 - FOR STATE REGISTER		1a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HILDA VIOLA BLACK		2a. DATE OF DEATH MONTH DAY YEAR FEB 22, 1986		2b. HOUR 1240 <sup>P</sup>			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 23 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD			
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Asst.		12b. KIND OF BUSINESS OR INDUSTRY Doctor's Office			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9016 Bethel Rd. 21701			
14. FATHER'S NAME FIRST MIDDLE LAST Maurice D. Slifer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola B. Rice		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. - - - - - 213-16-0620		17. INFORMANT ADDRESS Mr. George W. Black, 9016 Bethel Rd. Frederick, Maryland 21701							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>resp arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EXTENSIVE COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 22</u> , 19 <u>86</u> , to <u>2/23</u> , 19 <u>86</u> that (we) last saw the deceased alive on <u>2/22</u> , 19 <u>86</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/23/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. P. G. Rausch M.D.				22e. ADDRESS #4 West 7th St., Fred. Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.			
24. FUNERAL DIRECTOR Smith Keeney Basford Funeral Home, 106 East Church St., Frederick, Md 21701				25a. DATE REC'D. BY REGISTRAR FEB 26 1986				25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 0 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
KENNETH NEIL BOSTIAN		02/21/86		5:5A M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7b. CITIZEN OF WHAT COUNTRY?	
MALE	WHITE	06/19/35	50	U.S.A.	
7a. BIRTHPLACE (STATE OR FOREIGN)	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		FREDERICK			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY		
FREDERICK	FREDERICK MEMORIAL HOSPITAL	REPAIR SERV.	AUTOMOTIVE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. MODE CITY LIMITS?	13c. STREET ADDRESS	13d. ZIP CODE	
MD CARROLL MIDDLEBURG		YES <input type="checkbox"/> NO <input type="checkbox"/>	5762 MIDDLEBURG RD.	21768	
14. FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
ROBERT LESLIE BOSTIAN		CATHERINE HYDE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
NO		143-26-8328		CATHERINE H. BOSTIAN 5762 MIDDLEBURG RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY					
(a) IMMEDIATE CAUSE (in)					days
DUE TO, OR AS A CONSEQUENCE OF					days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					1 year/months
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
COPD					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
2/18	lung cancer	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>	(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE					22c. DATE SIGNED
[Signature]					2/21/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS
Allen G. [Signature]					1475 Taney Ave. Fred MD
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	02/24/86	HAUGHS CEMETERY	LADIESBURG FRED. MD		
24 FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
D. D. HARTZLER		FEB 26 1986	[Signature]		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed in the box 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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RECEIVED



Page 1

071209

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 0 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOIS VIRGINIA BOYER			2a. DATE OF DEATH MONTH DAY YEAR 2 22 86		2b. HOUR 0128M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 27 1917		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. MONTHS DAYS		
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Tech.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.				

13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 311 Thomas Ave., 21701	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer E. Nikirk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Goldyo Mae Brandenburg							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - - - 214-10-2394			17. INFORMANT ADDRESS Mr. John D. Boyer, 311 Thomas Ave. Frederick, Maryland 21701				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY INSUFFICIENCY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>BILATERAL PNEUMONIA</u>		1 week	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>AMYOTROPHIC LATERAL SCLEROSIS</u>		10 years	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 2/21/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERITONEAL GASTROSTOMY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (the doctor) attended the deceased from 2/15 19 86 to 2/22 19 86, that (I) last saw the deceased alive on 2/21 19 86, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.

22b. SIGNATURE James S. Grissom M.D.		DEGREE M.D.		22c. DATE SIGNED 2/22/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES S. GRISSON M.D.		22e. ADDRESS 1475 TANEY AVE SUITE 204 FREDERICK, MD. 21701			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Feagaville Frederick Md.	
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24. FUNERAL DIRECTOR Smith Keeney & Basford Funeral Home, 106 E. Church St., Frederick, Md. 21701		25a. DATE REC'D BY REGISTRAR FEB 26 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Bondell	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please send page 4 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



055201

FOR  
1 - STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 2 0 5

1. DECEASED NAME (Last or First) <b>MEDNA YOUNG CANNON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 12, 1986</b>		2b. HOUR <b>12:05 P.</b>						
1. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Braddock Hgts.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Vindabona Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Pa.</b>			13b. COUNTY <b>Warren</b>		13c. CITY OR TOWN <b>Warren</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>111 West St. 16365-9999</b>		
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Albert Young</b>			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Susan Andregg</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>161-22-8954</b>			17. INFORMANT <b>Jean Adamson</b>			ADDRESS <b>21769 Middletown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>DEHYDRATION</b>											<b>1-2 WKS</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>PROLONGED GASTROENTERITIS</b>											<b>1 MONTH</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>110</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/17, 19 82</b> to <b>2/12, 19 86</b> , that <b>(I)</b> saw the deceased alive on <b>2/10 2/12</b> , 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wayne Augmer</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/13/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wayne Augmer</b>			22e. ADDRESS <b>Brunswick, Md. 21716</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 15, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warren Pa.</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 19 1986</b>	
24. FUNERAL DIRECTOR NAME <b>Thompson Funeral Home</b>			ADDRESS <b>Middletown, Md.</b>			25a. REGISTRAR'S SIGNATURE <b>[Signature]</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP  
FORM 1-6-50M A/83  
(VRA 15, 4)







065163

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 0 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
James		Hamilton		Carroll				2		13	86	1508p.m.		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 YRS.				
Male		Negro		April 2, 1936		49		MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
District of Col.		USA				Frederick County, MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Frederick		Frederick Memorial Hospital		Laborer		Construction								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
Maryland		Frederick		Adamstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3125 Flint Hill Rd. / 21710						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
James		Hamilton		Carroll, Sr.		Cora		Frances		Hill				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		214-32-2663		Cora F. Carroll - Adamstown, Md.		3125 Flint Hill Rd. 21710								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Large cell bronchogenic carcinoma - extensive metastases, poorly differentiated.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 yr -

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Emphysema 2° to above Dx.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		8, 19 85, to		2-13-19 86, that (I) (we) last saw the deceased alive on		2-13-86, 19	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				2-13-86	
Rex B. Martin		220 N. Market St. Frederick Md 21701					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/19/86		Hopehill Cemetery		Hopeland, Frederick, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John T. Williams Funeral Home Brunswick, Md.				FEB 24 1986		Julia Davidson-Russell	

B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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FIELD



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the death certificate must be completed at autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 5 2 0 7 REG. NO.	
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) <b>Roy Elwood CLINE, SR.</b>						2a DATE OF DEATH MONTH DAY YEAR <b>February 8, 1986</b>		7b HOUR <b>p. M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 17, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>					
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Mechanic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>City of Fred</b>			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Frederick</b> 13c CITY OR TOWN <b>Frederick</b>						13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>4915 Old Swimming Pool Rd. 21701</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Thomas Cline</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Devilbiss</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>220-30-7774</b>		17 INFORMANT ADDRESS <b>Mrs. Alta G. Cline, 4915 Old Swimming Pool Rd., Fred. Md. 21701</b>							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, terminal</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>MI</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>6.I. bleeding with syncope, recurrently, also probable, old MI</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <b>2-22-1986</b> to <b>2-8-1986</b> that (I) (we) lost saw the deceased alive on <b>2-8-1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Rex R. Martin</b> DEGREE <b>M.D.</b>						22c DATE SIGNED <b>2-8-86</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Rex R. Martin, M.D.</b>				22e ADDRESS <b>220 North Market St., Fred. Md. 21701</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Feb. 12, 1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Frederick Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Smith Reene</b>		24b ADDRESS <b>East Church St., Fred. Md. 21701</b>		25a DATE REC'D. BY REGISTRAR <b>FEB 13 1986</b>		25b REGISTRAR'S SIGNATURE <b>John G. Riddell</b>					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 0 8  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARA ANNA CORSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 3, 1986</b>			2b. TIME OF DEATH <b>4:00 P.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 24, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co.</b>			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, TYPE STREET ADDRESS) <b>Homewood Retirement Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>			13b. CITY OR TOWN <b>Fred.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>4832 Round Hill Rd. 21701</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CARL WAGNER II</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ELIZABETH BOKH</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>263-04-3974</b>		17. INFORMANT ADDRESS <b>Carl Corson Frederick, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Heart Dis</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes Mell</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12-27 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> , 19 <b>86</b> , to <b>2-3</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>2-3</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>T. Stone</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-4-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas E STONE</b>			22e. ADDRESS <b>4W3 W. ST Frederick, Md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 6, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Fred. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Thompson Funeral Home</b>			ADDRESS <b>21769 Middletown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 06 1986</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. Davidson-Randall</b>		

BP

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CLARA A. COOPER  
Feb. 3, 1936

Feb. 3, 1936  
Dec. 2, 1935

Feb. 3, 1936  
Feb. 3, 1936

Feb. 3, 1936  
Feb. 3, 1936

Feb. 3, 1936  
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051199

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 0 9

REG. NO.

1. DECEASED NAME (PRINT OR PRINT) FIRST MIDDLE LAST Gladys Lorraine Cosgrove			2a. DATE OF DEATH MONTH DAY YEAR February 11, 1986		2b. HOUR M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR March 29, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.	
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) aircraft	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1100 Poplar Street 21701
14. FATHER'S NAME FIRST MIDDLE LAST Belen Harsh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rozela			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-10-4519		17. INFORMANT ADDRESS Nettie M. Cosgrove, Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoid Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20/86</u> 19 <u>86</u> to <u>2/11/86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1/20/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Frederic H. Kass III</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/12/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass III		22e. ADDRESS 1825 Howell Rd Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Feb. 13, 1986	23c. NAME OF CEMETERY OR CREMATORY Park Heights Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brunswick, Fred., Maryland	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 18 1986			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

BP





045144

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 1 0  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Robert EARL COWDEN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 9, 1986</b>		2b HOUR <b>6:20 P.M.</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 24, 1918</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Florida</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Frederick</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Carroll</b>	13c CITY OR TOWN <b>Mt. Airy</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Earl G. Cowden</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah G. Verdell</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW 2</b>	17 INFORMANT <b>Mrs Gloria Jean Austin,</b>		ADDRESS <b>Item 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE END-STAGE COPD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLE PULMONARY EMBOLI</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) <del>did not</del> <b>did</b> attend the deceased from <b>2/9</b> <b>86</b> to <b>2/9</b> <b>86</b> that <b>a</b> (we) last saw the deceased alive on <b>2/9</b> <b>86</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, <b>(we)</b> <del>did not</del> view the body after death.					
22b SIGNATURE <b>James S. Grisson M.D.</b>			DEGREE <b>M.D.</b>		22c DATE SIGNED <b>2/10/86</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>James S. Grisson M.D.</b>			22e ADDRESS <b>1475 TANEY Ave. Suite 204 Frederick, Md. 21701</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>Feb. 13, 1986</b>	23c NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montg., Md.</b>	
24 FUNERAL DIRECTOR <b>Orin L. Molesworth, P.A.,</b>			ADDRESS <b>Damascus, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>FEB 13 1986</b>
			25b REGISTRAR'S SIGNATURE <b>Galia Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B, report any injury, or other traumatic event, the medical examiner will be notified at once.

Subject: [illegible]  
Date: Nov. 24, 1954  
Location: [illegible]  
Reference: [illegible]  
Remarks: [illegible]

Personnel: [illegible]  
Equipment: [illegible]  
Weather: [illegible]  
Remarks: [illegible]

Summary: [illegible]  
Remarks: [illegible]

Remarks: [illegible]

Remarks: [illegible]

058021

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 1 1  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BAYLOR ULYSSES CRIST, JR.			2a. DATE OF DEATH MONTH DAY YEAR 2 18 86			2b. HOUR 8:05 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH March 24, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick, MD.	
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist-Ret.		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Baylor Ulysses Crist, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Elizabeth Bell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-1616A	
17. INFORMANT ADDRESS 7204 Bowers Road Frederick, Md. 21701		17. INFORMANT Mrs. Sandra L. Crist		17. INFORMANT Mrs. Sandra L. Crist		17. INFORMANT Mrs. Sandra L. Crist	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

ischemia heart Cerebral artery disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from Feb 5, 19 86, to Feb 18, 19 86, that (I) (we) last saw the deceased alive on Feb 18, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE <u>Red C. Hallen</u>	DEGREE M.D.	22c. DATE SIGNED 2/24/86
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Red C. Hallen</u> , M.D.	22e. ADDRESS <u>1425 Long an</u>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-21-1986	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Maryland
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24a. DATE REC'D. BY REGISTRAR FEB 25 1986	24b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALSO WITH FORM PM 3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05212

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VIRGINIA PALMER CROSS			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 2 1986			2b. HOUR 8A <sub>M</sub>			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 5 1909	6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 2 1986			2d. HOUR 8A <sub>M</sub>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK COUNTY MD.			
10. CITY OR TOWN OF DEATH WALKERSVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10619 WOODSBORO PIKE 21793				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE MARYLAND		13b. COUNTY FREDERICK		13c. CITY OR TOWN WALKERSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 10619 WOODSBORO PIKE, 21793			
14. FATHER'S NAME FIRST MIDDLE LAST R. V. PALMER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA UNKNOWN WALTERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT HARRY W. LEWIS		ADDRESS 10619 WOODSBORO PIKE WALKERSVILLE, MD. 21793			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10. <u>Coccyx Fract</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Robert J. Thomas</u>			TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER 812 Toll House Ave. Frederick, Md. 21701		DATE SIGNED 2/2/86		
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.			ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE FEB. 3, 1986		23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SMITHSBURG WASHINGTON MD.		
24. FUNERAL DIRECTOR NAME ROBERT E. DAILEY & SON			ADDRESS 615 EAST MAIN STREET THURMONT, MD. 21788		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Felix Davidson-Randall</u>		

FEB 13 1986

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 1 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Dise DAVIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 19, 1986</b>			2b. HOUR <b>2:19 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 7, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>IF UNDER 24 HRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retail Manger</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothes</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1211 Pinewood Drive 21701</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alvin Percey Dise</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Rowe</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>205-16-6125</b>		17. INFORMANT <b>Richard Davis 1211 Pinewood Drive Frederick, Md. 21701</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Hepato renal Syndrome*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*hepatic cirrhosis*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>2/19 86</b> , that (I) (we) last saw the deceased alive on <b>2/18 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) said I did not view the body after death.)							
22b. SIGNATURE <i>Philip Shapiro</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Philip Shapiro</b>				22e. ADDRESS <b>814 Toll House Ave., Frederick, Md. 21701</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Feb. 20, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION <b>Smithsburg, Washington, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Smith, Keeney &amp; Basford Funeral Home 106 East Church St., Frederick, Md. 21701</b>				25a. DATE RECD. BY REGISTRAR <b>FEB 24 1986</b>		25b. REGISTRAR'S SIGNATURE <i>L. J. Krishna Pandey</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subsequent pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, contact the medical examiner and a body should not be released until one.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605214

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES EMORY DILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 20, 1986</b>		2b. HOUR <b>744 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 11 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK MD.</b>	
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTHAMPTON MANOR NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ROAD WORK</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>LOCAL GOVT.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>FREDERICK</b>	13c. CITY OR TOWN <b>WOODSBORO</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE EMORY DILLER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE J. THOMAS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>World War I 220-01-4386</b>		17. INFORMANT ADDRESS <b>Woodsboro, MD</b> <b>Mary Cutsail 11606 Creagerstown Rd.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Consecutive HEART FAILURE & shock**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ARTERIOSCLEROTIC CARDIO-VASCULAR**

DUE TO, OR AS A CONSEQUENCE OF

**DISEASE**

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>12 Feb</b> 19 <b>86</b> to <b>20 Feb</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>20 Feb</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Gery L. Smith</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>20 Feb. 86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2/24/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Frederick MD</b>
24. FUNERAL DIRECTOR NAME <b>G. Douglas Stauffer</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1986</b>	25b. REGISTRAR'S SIGNATURE <b>Jane Davidson Gordon</b>
1621 Opossumtown Pike, Frederick, MD			

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070126

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary Mildred DOODY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 27, 1986</b>		2b. HOUR MIN. <b>9:00A</b>								
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>70</b>		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b>						
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>707 Wyngate Drive</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>						13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>707 Wyngate Drive 21701</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>			17. INFORMANT ADDRESS <b>Bugene Doody Jr., 707 Wyngate Dr. Frederick, Md. 21701</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>High B.P. &amp; Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Diabetes mellitus</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>5-13</b> 19 <b>54</b> , to <b>2-27</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>2/23/86</b> 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Rex R. Martin</b>						DEGREE			22c. DATE SIGNED <b>Feb. 28, 1986</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Rex R. Martin</b>						22e. ADDRESS <b>220 North Market St., Frederick, Md. 21701</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>March 1, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Clivest Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Smith, Keeney &amp; Basford Funeral Home 106 East Church St., Frederick, Md. 21701</b>													
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*[Faint, mostly illegible text and markings covering the page, including what appears to be a large 'X' or 'Z' shape in the center.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 0 5 2 1 6  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

070144

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beulah Estella DRAPER			2a. DATE OF DEATH MONTH DAY YEAR February 10, 1986		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 8, 1898	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.		
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizen's Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY Wash.	13c. CITY OR TOWN Smithsburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 1 21783	
14. FATHER'S NAME FIRST MIDDLE LAST William D. L. Harne			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie - Wise		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-6204		17. INFORMANT ADDRESS Mr. Carroll W. Draper, Cavetown, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerotic Cardiovascular Disease

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) with congestive heart failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

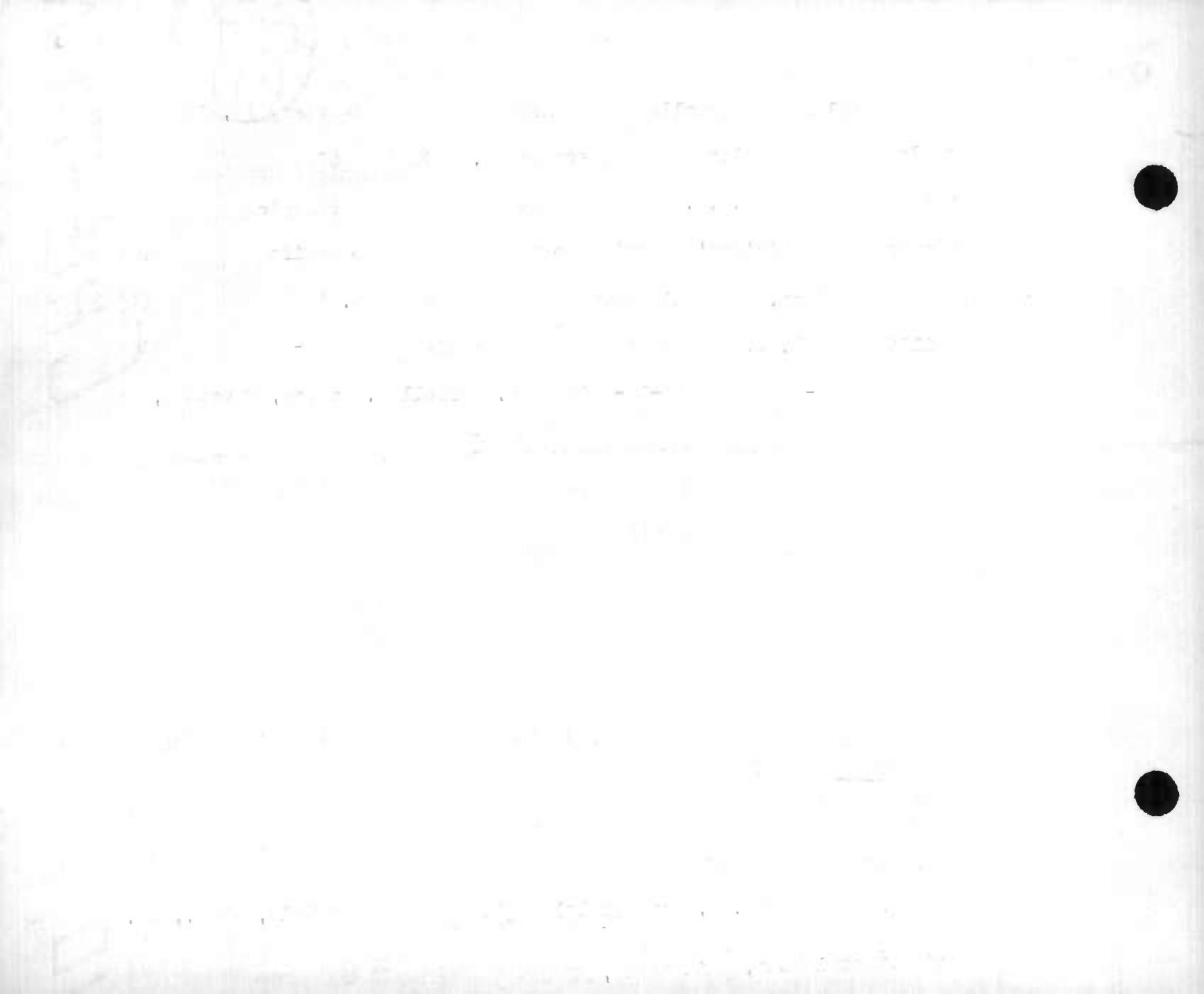
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1983, to Feb 10, 1986, that (I) (we) last saw the deceased alive on Feb. 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
22b. SIGNATURE Bernard D. Thomas Jr.	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/21/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard D. Thomas Jr.		22e. ADDRESS 228 N. Market St. Frederick, Md. 21701	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 13, 1986	23c. NAME OF CEMETERY OR CREMATORY Garfield United Methodist Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Garfield, Fred., Md.
24. FUNERAL DIRECTOR NAME Dennis L. Davis Davis Funeral Home, Smithsburg, MD 21783		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 03 1986 John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



066128

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

0 5 2 1 7

1. DECEASED NAME (TYPE OR PRINT) <u>Catherine Dawson Dykstra</u>			2a. DATE OF DEATH MONTH <u>2</u> DAY <u>23</u> YEAR <u>86</u>			2b. HOUR <u>1940</u> M					
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>Oct.</u> DAY <u>9</u> YEAR <u>1921</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>64</u> YRS		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		8. IF UNDER 24 HRS HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Frederick,</u> MD.					
10. CITY OR TOWN OF DEATH <u>Frederick</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>Frederick Memorial Hospital</u>				12a. USUAL OCCUPATION (USUAL WORK OR FIRST OF WORKING LIFE) <u>School Emp. Ret.</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Tennis Club</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Frederick</u> 13c. CITY OR TOWN <u>Frederick</u>											
14. FATHER'S NAME FIRST <u>Josie</u> MIDDLE <u></u> LAST <u>Dawson</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Helen</u> MIDDLE <u></u> LAST <u>Rounds</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>213-14-5171</u>		17. INFORMANT ADDRESS <u>Mr. Dewey I. Dykstra 901 Seminole Road Frederick, Md. 21701</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>extensive pooling</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>differentiated lymphoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 85</u> to <u>2/23 19 86</u> , that (I/we) last saw the deceased alive on <u>2/23 19 86</u> and that (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.											
23a. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>										23c. DATE SIGNED <u>2/23/86</u>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. G. Drayton</u>				23d. ADDRESS <u>4 West 7th Street Frederick, Md. 21701</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>2-24-1986</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Crematory</u>				23d. LOCATION CITY OR TOWN <u>Smithsburg</u> COUNTY <u>Washington</u> STATE <u>Md.</u>			
24. FUNERAL HOME <u>R.E. Dailey &amp; Son, PA</u>				25. DATE REC'D. BY REGISTRAR <u>Feb 28 1986</u>				26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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423TH VICTORY NOVA

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DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 2 1 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) EDNA VIRGINIA FLOOK			2a DATE OF DEATH MONTH DAY YEAR 9 15 86			2b HOUR 3 45 PM M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR January 2, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick MD			
10 CITY OR TOWN OF DEATH Frederick		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stitcher		12b KIND OF BUSINESS OR INDUSTRY Leather Factory	
13a STATE Maryland		13b CITY OR TOWN Frederick		13c CITY OR TOWN Myersville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 514 Main Street 21773	
14 FATHER'S NAME FIRST MIDDLE LAST John C Main				15 MOTHER'S MAIDEN NAME MIDDLE LAST Mollie L. Routzahn					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-8266		17 INFORMANT 15 Boffeau Court Sue A. Sheffler Middletown, MD 21769					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 WEEKS DUE TO, OR AS A CONSEQUENCE OF (c) 2 WEEKS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RIGHT HEMISPHERIC CEREBROVASCULAR ACCIDENT									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from JAN. 20, 19 86, to FEB 15, 19 86, that (I) (we) last saw the deceased alive on FEB 15, 19 86, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE James L. Roessler MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 2-15-86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. ROESSLER MD				22e ADDRESS MIDDLETOWN, MD. 21769					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2-18-86		23c NAME OF CEMETERY OR CREMATORY Mt. Zion U. Methodist		23d LOCATION Myersville Frederick Maryland			
24 FUNERAL DIRECTOR Ricketts Funeral Home Myersville, MD 21773				25a DATE REC'D. BY REGISTRAR FEB 24 1986		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall			

RECEIVED

LIBRARY



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel M Gehrke			2. DATE OF DEATH MONTH DAY YEAR 2 2 86			2b. HOUR 3:00 AM		
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02 24 97	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick county MD.					
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Lab			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Frederick		
14. FATHER'S NAME FIRST MIDDLE LAST Jake Moeckley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Wachter			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		
17. INFORMANT Robert A. Gehrke			ADDRESS 2777 Lynn St. Fred. Md.			21701		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension</i>								
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>3/14</i> , 19 <i>79</i> , to <i>2/2</i> , 19 <i>86</i> , that (I) (we) last saw the deceased on <i>1/29</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>A. Majeed</i>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/3/1986		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Majeed, M.D.			22e. ADDRESS 4 East Church St. Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-6-1986		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Park, Cook, Illinois	
24. FUNERAL DIRECTOR <i>R.E. Dailey &amp; Son, Pa</i>			1201 N. Market St. Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR 2/3/1986		
25b. REGISTRAR'S SIGNATURE <i>R.E. Dailey &amp; Son, Pa</i>			25c. REGISTRAR'S SIGNATURE <i>R.E. Dailey &amp; Son, Pa</i>					

BP



065195

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Earl William Gilbert			2a. DATE OF DEATH MONTH DAY YEAR 2 18 1986		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 12 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD	
10. CITY OR TOWN OF DEATH Harmony	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4441 Fishers Hollow Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	12b. KIND OF BUSINESS OR INDUSTRY State Roads	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Harmony	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 4441 Fishers Hollow Rd 21773
14. FATHER'S NAME FIRST MIDDLE LAST Milton M Gilbert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Babington		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 216-07-0333		17. INFORMANT Dennis W. Gilbert		ADDRESS 4441 Fishers Hollow Road Myersville, MD 21773	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>2/18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Jan 30</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Lloyd E. Halvorson</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>2/24/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lloyd E. Halvorson		22e. ADDRESS 1475 Toll House Ave., Frederick, MD 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-21-1986	23c. NAME OF CEMETERY OR CREMATORY Harmony Cenetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harmony Frederick Maryland	
24. FUNERAL DIRECTOR <u>Ricketts</u>		ADDRESS Ricketts Funeral Home Myersville, MD 21773		25a. DATE RECD. BY REGISTRAR <u>EB 24 1986</u>	25b. REGISTRAR'S SIGNATURE <u>John D. ...</u>

BP

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10-10-10

CHIEF

2000 CC 1101



10-10-10

044039

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 2 1

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Jenna Ann GINGELL		February 1, 1986		9:23p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	January 22, 1986	YRS. MONTHS DAYS	10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Frederick County MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Frederick	Frederick Memorial Hospital		infant		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	
Maryland	Frederick	Emmitsburg		17430 B N. Seton Ave. 21727	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Herbert Terryling		Loriann Seiferd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Emmitsburg, MD 21727	
				Herbert T. Gingell, 17430B N. Seton Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anencephaly</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>January 22, 1986</u> to <u>February 1, 1986</u> , that (I) (we) last saw the deceased alive on <u>February 1, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>J. Fred Baker</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>2/2/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Fred Baker</u>		22e. ADDRESS <u>1475 Taney Ave Frederick, Md 21701</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4 February 86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Emmitsburg Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Emmitsburg, Frederick MD</u>
24. FUNERAL DIRECTOR <u>Skiles Funeral Home, Emmitsburg, MD 21727</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 07 1986</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

05222

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR P. M.	
Mary Emma GROFF				February 9, 1986				6:43 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Aug. 1, 1905		80 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Frederick County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Frederick		Meridian Nursing Home				Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE			
Maryland		Frederick		Frederick		9825 Hall Road, 21701			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John H. Kunkel				Emma Laura Wallace					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		None		215-20-8741 Joseph M. Groff, 10215 Coalfont Crossing, Mt. Airy, Md. 21771					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Timothy Hickey, Jr.</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Timothy Hickey, Jr., M.D.				22e. ADDRESS Parkview Medical Center, Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Feb 12, 1986		Mt. Carmel Methodist		Frederick, Frederick, Md.			
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701				25a. DATE REC'D. BY REGISTRAR EB 14 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers			

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DATE: 01/20/2001 TIME: 14:00

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• 1990, 1991, 1992

DATE: 10/10/1964

059115

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

REG. NO.

0 5 2 2 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
FRANKLIN		JOSHUA		GRUBER				2/22/86								4:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IN YEARS LAST BIRTHDAY		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS					
MALE		WHITE		MONTH 5 DAY 24 YEAR 1910		75		YRS		MONTHS		DAYS		HOURS		MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH											
MD		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		FREDERICK										MD.	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17b. KIND OF BUSINESS OR INDUSTRY											
UNION BRIDGE		10932 GREEN VALLEY ROAD		MECHANIC		AUTO/REPAIR											
18a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18b. STATE		18c. COUNTY		18d. CITY OR TOWN		18e. INSIDE CITY LIMITS?		18f. STREET ADDRESS / ZIP CODE							
MD		FREDERICK		UNION BRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10932 Green Valley Rd.									
19. FATHER'S NAME		20. MOTHER'S MAIDEN NAME															
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
WILLIAM		GRUBER		ELIZABETH		ARNOLD											
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		21b. SOCIAL SECURITY NO.		21c. INFORMANT		21d. ADDRESS											
NO		N/A		217-10-0194		Naomi L. Gruber		10932 Green Valley									
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		23. PART I. DEATH WAS CAUSED BY:		24. IMMEDIATE CAUSE (a)		25. DUE TO, OR AS A CONSEQUENCE OF		26. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		27. DUE TO, OR AS A CONSEQUENCE OF		28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				liver failure								days					
				liver cirrhosis								years					
29. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		30. ascites, jaundice, ASCVD															
31a. DATE OF OPERATION		31b. CONDITION FOR WHICH OPERATION WAS PERFORMED		31c. AUTOPSY?		31d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
32a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		32b. TIME OF INJURY		32c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR															
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19															
33a. INJURY OCCURRED		33b. PLACE OF INJURY		33c. LOCATION		CITY OR TOWN		COUNTY		STATE							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET													
34. I certify that (I) (this hospital) attended the deceased from 7-4, 1986 to 1-27, 1986, that (I) saw the deceased alive on 1-27, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
35. SIGNATURE		36. DEGREE		37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED											
Ephraim Barzaga						2-24-86											
39. PHYSICIAN'S NAME (TYPE OR PRINT)		40. ADDRESS															
EPHRAIM BARZAGA		NEW WINDSOR, MD. 21776															
41. BURIAL, CREMATION, REMOVAL (SPECIFY)		42. DATE		43. NAME OF CEMETERY OR CREMATORY		44. LOCATION		CITY OR TOWN		COUNTY		STATE					
BURIAL		2/26/86		Rocky Hill Cemetery		Woodsboro		Frederick		MD							
45. FUNERAL DIRECTOR NAME		46. ADDRESS		47. DATE REC'D. BY REGISTRAR		48. REGISTRAR'S SIGNATURE											
G. Douglas Stauffer		1621 Opossumtown Pike, Frederick, MD		FEB 26 1986		John Davidson-Randall											

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through.]*

052113

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ida Beatrice HALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 11, 1986</b>			2b. HOUR <b>7:00 P</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 30, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9807 Hall Road 21701</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Calvin C. Cronwell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Louisa Baker</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-36-3994</b>		17. INFORMANT <b>Mrs. L. Louise Swartz 53 Hamilton Ave. Frederick, Md. 21701</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerotic Vascular Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 72</b> to <b>2/11</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>2/11/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles R. Clark</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>2/12/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Charles R. Clark</b>				22e. ADDRESS <b>4 West Seventh St., Frederick, Md. 21701</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 14, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>			
24. FUNERAL DIRECTOR'S NAME <b>Smith, Keeney &amp; Basford Funeral Home</b> 106 East Church St., Frederick, Md. 21701									
25. REGISTRAR'S SIGNATURE <b>John A. ...</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

February 1, 1961

Dear Sir:

Enclosed for you are

two copies of the report

of the

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committee on the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove stubs/borders. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

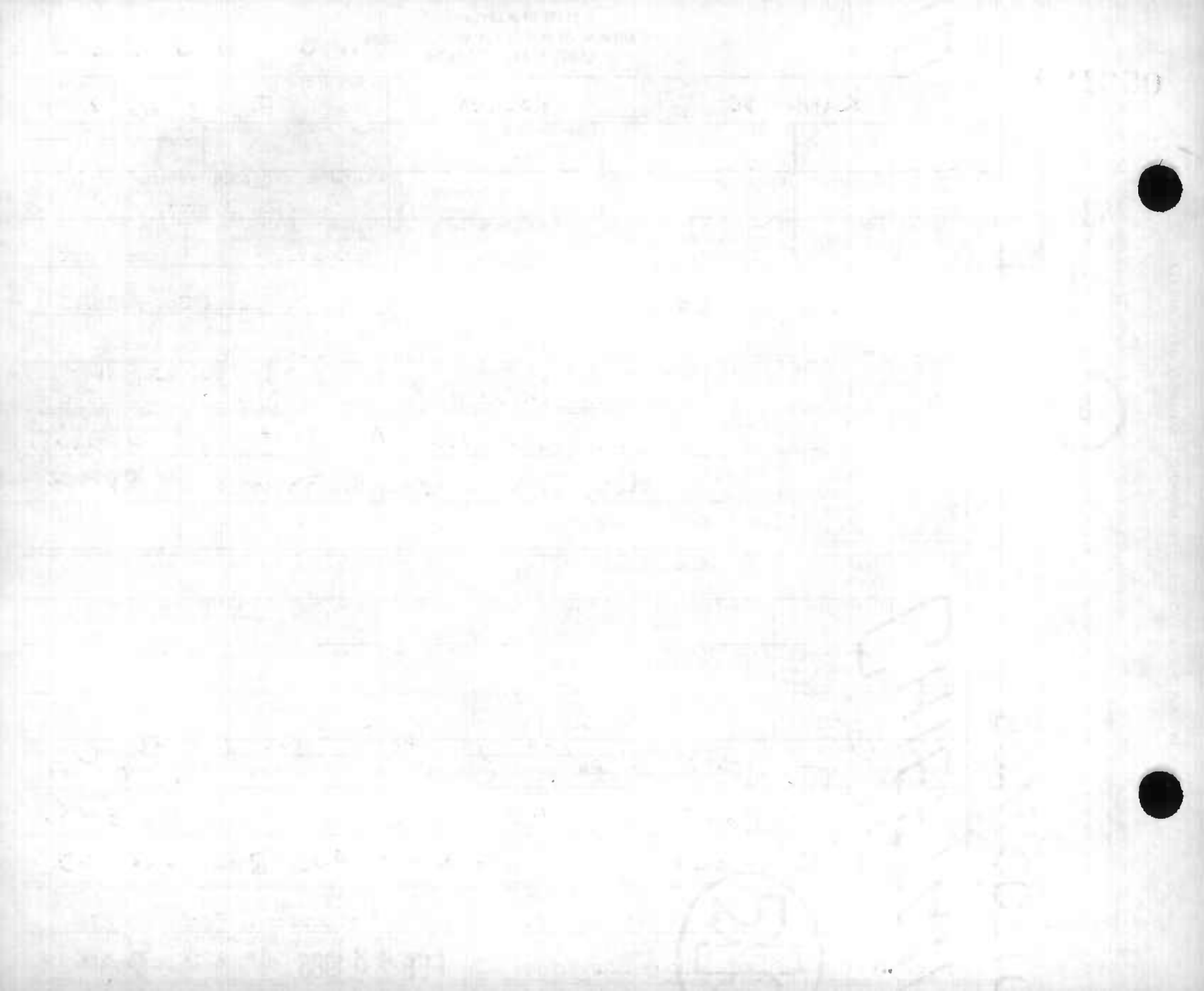
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 2 5

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		20. DATE OF DEATH		20. DATE OF DEATH		20. DATE OF DEATH		20. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH		20. DATE OF DEATH		20. DATE OF DEATH		20. DATE OF DEATH		20. DATE OF DEATH	
KATHERINE Elizabeth HALLER		Feb 3 86		2.10 PM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Dec. 30, 1900		85 YRS.		MONTHS DAYS		HOURS MIN.	
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Frederick County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		Housewife		Homemaker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Frederick		Brunswick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		605 Brunswick St. / 21716			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
William Edgar Angevine		Margaret Elizabeth Paige									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		214-30-2058		William L. Haller - Brunswick, Md.		605 Brunswick St. 21716					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Cerebrovascular Accident		IMMEDIATE CAUSE (a) Cerebrovascular Accident		IMMEDIATE CAUSE (a) Cerebrovascular Accident		IMMEDIATE CAUSE (a) Cerebrovascular Accident		IMMEDIATE CAUSE (a) Cerebrovascular Accident		IMMEDIATE CAUSE (a) Cerebrovascular Accident	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
(b) Arteriosclerotic Vascular Disease		(b) Arteriosclerotic Vascular Disease		(b) Arteriosclerotic Vascular Disease		(b) Arteriosclerotic Vascular Disease		(b) Arteriosclerotic Vascular Disease		(b) Arteriosclerotic Vascular Disease	
(c)		(c)		(c)		(c)		(c)		(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 86, to Feb 3, 19 86, that (I) (we) last saw the deceased alive on Feb 3, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 86, to Feb 3, 19 86, that (I) (we) last saw the deceased alive on Feb 3, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 86, to Feb 3, 19 86, that (I) (we) last saw the deceased alive on Feb 3, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 86, to Feb 3, 19 86, that (I) (we) last saw the deceased alive on Feb 3, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 86, to Feb 3, 19 86, that (I) (we) last saw the deceased alive on Feb 3, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 86, to Feb 3, 19 86, that (I) (we) last saw the deceased alive on Feb 3, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
L Kinland		MD		2-5-86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
L KINLAND		610 NINTH AVE, BRUNSWICK, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		2/6/86		Mt. Olivet Cemetery		Frederick, Frederick, Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John T. Williams Funeral Home Brunswick, Md.		FEB 13 1986		John T. Williams							







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. MIN.	
LORETTA Annie		HARDMAN		2/16/86		130P					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
Female		White		May 21, 1913		72		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PA		U.S.A.				Frederick County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		Housekeeper		Own House					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Frederick		Emmitsburg				807 W. Main St. 21727			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Amos		Bishop		Annie		Glacken					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		212-50-7667		Miss. June Hardman		Emmitsburg, MD 21727-0841 807 W. Main St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/86</u> , 19 <u>86</u> , to <u>2/16/86</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>2/15/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Gerald Winnan</u> MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2/16/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Gerald Winnan, M.D.		1475 Taney Ave. Frederick, MD 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		19 Feb 86		Emmitsburg, Memorial		Emmitsburg, Frederick, MD.					
24. FUNERAL DIRECTOR NAME ADDRESS		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Skiles Funeral Home, Emmitsburg, MD 21727-0427		FEB 24 1986		<u>Gerald Winnan</u>							

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1- FOR  
STATE  
REGISTRAR

MELVINE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 2 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FLORENCE MELVINE HEARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-23-86</b>		2b. HOUR <b>5:05 A</b>		
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-5-1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>MD Frederick Adamstown</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <b>1832 Pleasant View Road 21170</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CLAUDE Andrew Delauter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Ambush</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218-34-3602</b>		17. INFORMANT ADDRESS <b>Maynard M. Heard Sr 1832 Pleasant View Rd</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 HOURS</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>EPITHELIAL CELL CANCER OF UNKNOWN</b>		<b>2 MONTHS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>PRIMARY WITH EXTENSIVE PULMONARY + PLEURAL METASTASES</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
**BONE METASTASES, BRAIN METASTASES, LIVER METASTASES**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>1/22</b> 19 <b>86</b> , to <b>1/23</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) I did not view the body after death.							
22b. SIGNATURE <b>Brian P. Massaro MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/23/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRIAN P. MASSARO M.D.</b>				22e. ADDRESS <b>198 Thomas Johnson Dr., Frederick, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 26, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Fred MD</b>	
24. FUNERAL DIRECTOR NAME <b>C.E. Hicks III</b>				ADDRESS <b>1922 Forest Drive</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 3 1986</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMM - 16 60M 7/84  
(VRA 15, 4)FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 2 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) NANNIE ELMEADA HOPKINS			2a DATE OF DEATH MONTH DAY YEAR February 14, 1986		2b HOUR 7:00p <sub>M</sub>
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Aug. 21, 1885	6 AGE (IN YEARS LAST BIRTHDAY) 100 YRS.	7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Frederick, MD.		
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY Frederick	13c CITY OR TOWN Middletown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 4499 Tulip Tree Lane/21769	
14 FATHER'S NAME ADDISON HOPKINS		15. MOTHER'S MAIDEN NAME NANCY MARTIN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No	16b SOCIAL SECURITY NO. XXXXXXXXXX 220-48-1827	17 INFORMANT Mr. H. Bryce Hopkins 4499 Tulip Tree Lane Middletown, Md. 21769			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Timothy F. Hickey</u>		DEGREE M.D.		22c. DATE SIGNED 2-17-1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Timothy F. Hickey, M.D.		22e. ADDRESS Parkview Medical Center Frederick, Md. 21701			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 18, 1986	23c. NAME OF CEMETERY OR CREMATORY Highland Presbyterian	23d. LOCATION STREET, Harford, Maryland		
24. FUNERAL HOME, CATHOLIC CHURCH, OR OTHER PLACE OF BURIAL R. E. DARTLEY & SON, PA.		1201 N. Market Street Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR FEB 21 1986	25b. REGISTRAR'S SIGNATURE <u>Jane Anderson-Randall</u>

BP. \_\_\_\_\_

DHMM - 16 60M 7/84  
(VRA 15, 4)

CONFIDENTIAL



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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 601 WEST GASTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

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DHMH - 17

(VR A15 ME (5))

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05229

1. DECEASED NAME (TYPE OR PRINT)						FIRST	MIDDLE	LAST	20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 27 86 478										
GERALD DOUGLAS HORNER, JR.																			
2. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 19 59		6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 27 86 478		7d. HOUR					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD							
10. CITY OR TOWN OF DEATH EMMITSBURG				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) ROUTE 140				12a. USUAL OCCUPATION (TYPE OF WORK) DUPLICATION MACH. OPERATOR				12b. KIND OF BUSINESS NAT'L FIRE ACADEMY							
13a. STATE MARYLAND						13b. COUNTY FREDERICK		13c. CITY OR TOWN EMMITSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 LINCOLN AVE.		21727					
14. FATHER'S NAME FIRST MIDDLE LAST GERALD D. HORNER, SR.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE SAYLER													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. NONE		228-94-6195		17. INFORMANT ANDREA H. HORNER		ADDRESS 3 LINCOLN AVE.		EMMITSBURG, MD							
18. CAUSE OF DEATH (Enter only one cause per line (b), and (c)) PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) Multiple Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 2 27 86 P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 1 car auto											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway				21f. LOCATION CITY OR TOWN Frederick MD COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Robert J Thomas				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 812 Toll House Ave.				DATE SIGNED 2/27/86							
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.				ADDRESS Frederick, Md. 21701															
23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/25/86		23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY				23d. LOCATION CITY OR TOWN LEGORE		COUNTY FREDERICK		STATE MD					
24. FUNERAL DIRECTOR NAME D. D. HARTZLER				ADDRESS WOODSBORO, MD				25a. DATE REC'D. BY REGISTRAR FEB 26 1986				25b. REGISTRAR'S SIGNATURE							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 3 0  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Alice Elizabeth Huffer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Feb 8 1986</i>		2b. HOUR <i>11:48 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4 27 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Frederick County, MD</i>		
10. CITY OR TOWN OF DEATH <i>Frederick</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Frederick Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Saleslady</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing Retail</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Frederick</i>	13c. CITY OR TOWN <i>Frederick</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1507 West 7th St. 21701</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas A. Locke</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>May V. Willingham</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>820-06-1668</i>		17. INFORMANT ADDRESS <i>Mrs. Sandra Kay Sheckles, 5203 New Design Rd., Frederick, Md. 21701</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral infarction with profound</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>hemiparesis and coma due to</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral embolus</i> 2 1/2 wks.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Advanced atherosclerotic heart disease; atrial fibrillation</i>					
19a. DATE OF OPERATION <i>Jan 12 1986</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Coronary bypass (2 vessel)</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>Jan 64</i> to <i>Feb 8</i> 19 <i>86</i> , that (I) (last) lost saw the deceased alive on <i>Feb 8</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Henry V. Chase</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>Feb 9, 1986</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry V. Chase MD</i>		22e. ADDRESS <i>804 Tall House Ave Frederick, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Feb. 11, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick Frederick Md.</i>		24. FUNERAL DIRECTOR NAME <i>Shirley Keeney Basford P.A. Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 13 1986</i>	
25b. REGISTRAR'S SIGNATURE <i>John Davidson Rodella</i>		26. ADDRESS <i>106 E. Church St., Frederick, Md. 21701</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 6

0 5 2 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GENEVIEVE GARDNER JOY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>26 3 86</b>		2b. HOUR <b>02:40</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04/05/03 82</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b>		10. CITY OR TOWN OF DEATH <b>FREDERICK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) <b>FREDERICK MEMORIAL HOSPITAL</b>	
12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING YEARS) <b>FOOD SERVICE</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE <b>12061 MAIN ST. / 21762</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROY GARDNER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY GENEVIEVE DAVIS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>213-18-3621</b>		17. INFORMANT ADDRESS <b>ELEANOR LAMBERT 12061 MAIN ST.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>asthma</b> DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Alzheimers Disease</b>					
19a. DATE OF OPERATION <b>NO</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 26</b> 19 <b>86</b> to <b>Feb 3</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Jan 31</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the said opinion was the basis for death.			
22b. SIGNATURE <b>Lloyd E. Hartzler</b>		DEGREE		22c. DATE SIGNED <b>2/3/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lloyd E. Hartzler</b>		22e. ADDRESS <b>1425 Tany Ave, Frederick MD</b>		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>02/06/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FAIRMOUNT CEMETERY</b>	
23d. LOCATION <b>LIBERTYTOWN FRED. MD</b>		24. FURNERAL DIRECTOR NAME <b>D. HARTZLER</b>			
25a. DATE REC'D BY REGISTRAR <b>FEB 07 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER

100% COTTON FIBER



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 3 2  
REG. NO.

1- FOR  
STATE  
REGISTRAR

071030

1. DECEASED NAME (TYPE OR PRINT) CLARENCE NELSON KLINE			2a. DATE OF DEATH MONTH DAY YEAR February 28, 1986		2b. HOUR 1:30 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR January 31, 1899	6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.		
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6410 Mt. Philip Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dairy Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. STATE Maryland					
13b. COUNTY Frederick		13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Rufus Nelson Kline		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Jane Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-28-2760		17 INFORMANT 6410 Mt. Philip Road Frederick, MD 21701	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>NEPHROSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1985</u> to <u>Feb. 28, 1986</u> , that (I) (we) last saw the deceased alive on <u>22 February, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE <u>George I. Smith, Jr.</u> MD.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 28 FEB 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George I. Smith, Jr.		22e. ADDRESS 804 Toll House Ave., Frederick, MD 21701	

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial	23b. DATE Mar. 3, 1986	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION WOODSBORO Frederick Maryland
24. FUNERAL DIRECTOR <u>Myersville</u> Ricketts Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 05 1986	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be circulated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 showing any injury, or other traumatic event, the medical examiner must be notified.

WIKIPIEDIA

GREEN COTTON 2002

Green Cotton 2002

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042119

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 2 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Irene Lease			2a. DATE OF DEATH MONTH DAY YEAR 2-4-86		2b. HOUR 8 <sup>10</sup> AM										
3. SEX female		4. RACE w		5. DATE OF BIRTH MONTH DAY YEAR 3 17 92		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lewistown, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.									
10. CITY OR TOWN OF DEATH Frederick, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewing		12b. KIND OF BUSINESS OR INDUSTRY Factory							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7th Street Frederick 21701			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Isaac Stevens						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Crum									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Waltersville, Md. 21793		17a. ADDRESS 10412 Glade Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED					
22a. I certify that (I) (this hospital) attended the deceased from 2/4 1986 to 2/4 1986, that (I) (we) last saw the deceased alive on 2/4 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE T. F. Hickey		DEGREE Park View Medical Center, Frederick	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. F. Hickey						22e. ADDRESS Park View Medical Center, Frederick									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/6/86		23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE nr. Woodsboro Fred. MD					
24. FUNERAL DIRECTOR NAME S. D. Hartzler						ADDRESS Woodsboro, Md.		25a. DATE REC'D. BY REGISTRAR FEB 07 1986		25b. REGISTRAR'S SIGNATURE John Davidson					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.





052098

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605234

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James Henry LESTER			2a. DATE OF DEATH MONTH DAY YEAR 2/13/86		2b. HOUR 8:30 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1923		
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		6b. CITIZEN OF WHAT COUNTRY? U.S.A.		6c. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		7c. IF UNDER 1 YEAR MONTHS DAYS		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.				
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		
12b. KIND OF BUSINESS OR INDUSTRY Transit Company						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland						
13c. COUNTY Frederick		13d. CITY OR TOWN Adamstown		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Harvey Lester		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sillie Mae Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II 233030-8657		17. INFORMANT ADDRESS 2740 Park Mills Rd., Adamstown, Md. 21710		
18. CAUSE OF DEATH (Enter only one cause per line for PART 1. If more than one cause, state the immediate cause (a), the condition (b), and the underlying cause (c).)						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF <u>Smoking</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Smoking</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>yes</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <u>Allen Gilson</u>		DEGREE		22c. DATE SIGNED 2/13/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. Gilson		22e. ADDRESS 1475 TANEY Ave, Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 16, 1986		23c. NAME OF CEMETERY OR CREMATORY Elm Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Adamstown, Frederick, Maryland						
24. FUNERAL DIRECTOR <u>Richard C. Basford</u> Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR FEB 18 1986				
25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>						

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

56-1051

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042033

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 2 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BLOYCE BLOYCE COOPER LEWIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 4, 1982 4 86 6:44 AM</b>		2b. HOUR
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 13, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.		
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Govt. Emp.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Guild Cooper Lewis</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elmina Lewis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>490-10-8925</b>		17. INFORMANT ADDRESS <b>1506 W. 9th St. Frederick, Md. 21701</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 dy</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19 86 11 15</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from <b>8/1/81</b> 19 <b>86</b> to <b>2/4</b> 19 <b>86</b> that (I/we) last saw the deceased alive on <b>2/3</b> 19 <b>86</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.					
22b. SIGNATURE <b>Dr. H. Conn</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Petry H. Cowan MD</b>				22e. ADDRESS <b>4 W 2th ST Frederick MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/7/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>EEB 07 1986</b>			
24. FUNERAL DIRECTOR <b>R. E. Dailey &amp; Son, P.A.</b>				25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 3 6  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Helen Mae LITTLE</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 24, 1986</b>			2b HOUR <b>8:30 PM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 27, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE/CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Maryland</b>		13b COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Frederick</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>5771 Sunsetview Lane, 21701</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Reid</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Richard N. Amin, 5771 Sunsetview Lane, Frederick, Md. 21701</b>					
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive Pulmo. Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Tobacco Habitation</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Allen L. Smith</b> DEGREE						22c. DATE SIGNED <b>2/25/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen L. Smith</b>						22e ADDRESS <b>1775 Taney Ave Frederick, Md. 21701</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Feb 26, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Washington, Md.</b>		
24 FUNERAL DIRECTOR <b>Smith, Keeney and Basford Funeral Home</b>						25. DATE OF REGISTRATION <b>FEB 28 1986</b>			
106 East Church St., Frederick, Md. 21701									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP \_\_\_\_\_

DATE: 10/10/58

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

065189

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 3 7  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RUTH ANTOINETTE MAC FARLAND		2a. DATE OF DEATH MONTH DAY YEAR 2 15 86		2b. HOUR 1240 PM	
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 24, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.	
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY None
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Adamstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST William A. Rutherford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bredina Laurie			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 679-14-5500D		17. INFORMANT ADDRESS 2995 Hope Mills Lane Mr. Charles R. Mac Farland Adamstown, Md. 21710	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>resp arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>extensive ovarian ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with bowel obstruction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>no</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 7, 1986</u> to <u>2/15, 1986</u> , that (I) (we) lost saw the deceased alive on <u>2/15, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <u>[Signature]</u> DEGREE				22c. DATE SIGNED <u>2/15/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D G Rausch</u>				22e. ADDRESS <u>4 West Scurry</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/22/86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Georges, Md.		23e. DATE REGD. BY REGISTRAR FEB 21 1986			
24. FUNERAL DIRECTOR (NAME) <u>R. E. Dailey &amp; Son, P. A.</u> ADDRESS <u>1201 N. Market St. Frederick, Md.</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified and a report sent.

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2005-10-10

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 3 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>HELEN RUTH MCCARTER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>FEB. 22, 1986</b>			2b HOUR <b>14:16<sup>P</sup></b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 10, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.				
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b KIND OF BUSINESS OR INDUSTRY <b>IRS</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Myersville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>6 Walnut Street 21773</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Arthur McClean</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella McKnight</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216 46 2027</b>		17 INFORMANT ADDRESS <b>G. Spangler Stroup 8 Walnut Street Myersville, MD 21773</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days.</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**CHRONIC PULMONARY DISEASE (OBSTRUCTIVE); DIABETES.**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>November 19 85</b> to <b>Feb 22 19 86</b> that (I) (we) last saw the deceased alive on <b>Feb 21 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE <b>Michael S. Rudman, MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>2-22-86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL S. RUDMAN</b>				22e ADDRESS <b>Middleton, MD 21769</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>2-23-86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg Washington Maryland</b>	
24a FUNERAL DIRECTOR <b>Ricketts Funeral Home</b>				24b ADDRESS <b>Myersville, MD 21773</b>		25a DATE REC'D. BY REGISTRAR <b>FEB 28 1986</b>	
				25b REGISTRAR'S SIGNATURE <b>Julia Davidson-Pondale</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that no death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please retain this permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



052233

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These detached pages must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 2 3 9

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ethel Moss MORRIS			2a DATE OF DEATH MONTH DAY YEAR February 14, 1986		2b HOUR 12:05 <sup>A.</sup>
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR August 6, 1987		6 AGE (IN YEARS LAST BIRTHDAY) 98	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD	
10 CITY OR TOWN OF DEATH Frederick	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home of Fred. Co.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland	13b COUNTY Frederick	13c CITY OR TOWN Adamstown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 5544 Mountville Rd., 21710	
14 FATHER'S NAME FIRST MIDDLE LAST Cosby		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia Rhoades			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	17 INFORMANT ADDRESS Betty Green, 5544 Mountville Rd., Adamstown, Md. 21710			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Age</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a <u>Chronic cholelithiasis</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 <u>77</u> to <u>2/14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Charles R. Clark</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>2/14/86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles R. Clark, M.D.		22e ADDRESS 4 West Seventh St., Frederick, Md. 21701			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Feb 16, 1986	23c NAME OF CEMETERY OR CREMATORY Zoar Baptist Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Locust Grove, Orange, Virginia		
24 FUNERAL DIRECTOR <u>Robert C. C. Basford</u> Smith, Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701		25a DATE REC'D. BY REGISTRAR FEB 17 1986		25b REGISTRAR'S SIGNATURE <u>Julia Davidson Randall</u>	

BP



052223

Items 18-22a 3/21/86 mlb F-61

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05240

1. DECEASED NAME (TYPE OR PRINT) <b>Ricky Allen Myers</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 13 1986</b>		2b. HOUR M <b>6:34P</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06 12 57</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>28</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b>		10. CITY OR TOWN OF DEATH <b>Frederick</b>		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>FREDERICK</b> 13c. CITY OR TOWN <b>FREDERICK</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>Frederick, MD 21 E. Fourth St., 21701</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALTON MYERS, SR.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDITH MAE PENWELL</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-68-9695</b>		17. INFORMANT <b>Edith Mae Myers</b> ADDRESS <b>Frederick, MD 21 E. Fourth St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ketoacidosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Bronchopneumonia</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER		DATE SIGNED <b>2/15/86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>		ADDRESS <b>111 Penn St. Balto.MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2/17/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gardens</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Frederick MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>G. Douglas Stauffer</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 19 1986</b>	25b. REGISTRAR'S SIGNATURE <i>James Gordon Riddle</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLACE OF ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 2 4 1

1 DECEASED NAME (TYPE OR PRINT) <del>XXXXXXXXXX</del> <b>ROLAND</b> <del>XXXXXXXXXX</del> <b>LEE</b> <del>XXXXXXXXXX</del> <b>MYERS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>2-4-86</b>		2b HOUR <b>1555</b> M	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 20, 1916</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		7a CITIZEN OF WHAT COUNTRY? <b>USA</b>		7b HOUR MONTHS DAYS HOURS MIN.		
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.		
11 CITY OR TOWN OF DEATH <b>Frederick</b>		12 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		13 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		
14 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Frederick</b> 13c CITY OR TOWN <b>Jefferson</b>		15 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16 STREET ADDRESS / ZIP CODE <b>4825 Pioneer Circle 21755</b>		
17 FATHER'S NAME FIRST MIDDLE LAST <b>Leonard J. Myers</b>		18 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn G. Wetzel</b>				
19 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		20 SOCIAL SECURITY NO. <b>220-03-5947</b>		21 INFORMANT ADDRESS <b>Jefferson, Md. 21755</b>		
22 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Insufficiency</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>9 years</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Renal Insufficiency</b>						
23a DATE OF OPERATION		23b CONDITION FOR WHICH OPERATION WAS PERFORMED		23c AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
24a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		24c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
25a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		25b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c LOCATION STREET CITY OR TOWN COUNTY STATE		
26 I certify that (I) (this hospital) attended the deceased from <b>Jan 31, 1986</b> to <b>Feb 4, 1986</b> that (I) (we) last saw the deceased alive on <b>Feb 4, 1986</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
27a SIGNATURE <b>L Kinland</b>		27b DEGREE <b>MD</b>		27c DATE SIGNED <b>2-5-86</b>		
27d PHYSICIAN'S NAME (TYPE OR PRINT) <b>L KINLAND</b>		27e ADDRESS <b>610 NINTH AVE Brunswick, MD</b>				
28a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		28b DATE <b>Feb. 7, 1986</b>		28c NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gard.</b>		
28d LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Maryland</b>		29 DATE REC'D. BY REGISTRAR <b>FEB 4 1986</b>				
30 FUNERAL HOME <b>R. E. Dailey &amp; Son, P.A.</b>		31 REGISTRAR'S SIGNATURE <b>Frederick, Maryland</b>				

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 4 2  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Myrtle E Nail</i> Nail			2a. DATE OF DEATH MONTH DAY YEAR <i>Jan 18 1986</i>		2b. HOUR MIN. <i>11:50 AM</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 1, 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>13 6 17</i>	IF UNDER 1 YEAR IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Frederick</i> MD.	
10. CITY OR TOWN OF DEATH <i>Frederick</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Citizens Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Frederick</i>	13c. CITY OR TOWN <i>Middletown</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>6403 Middletown Rd. 21769</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Vernon Stanley Runkles</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen Irene Wright</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-16-1848</i>		17. INFORMANT ADDRESS <i>Joan M. Shafer, Same As Above</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Renal failure*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*2 days*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Cerebral Thrombosis**3 weeks*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Generalized Arterio-Sclerosis**5 yrs*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*Diabetes*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>March 21 1984</i> to <i>Jan. 1986</i> , that (I) <del>lost</del> lost saw the deceased alive on <i>Jan. 18 1986</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was not</del> did not view the body after death.			
22b. SIGNATURE <i>Bernard W. Thomas Jr.</i>		DEGREE	22c. DATE SIGNED <i>Jan. 1986</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. O. Thomas, Jr.</i>		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>1-22-1986</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Locust Grove</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick, Md.</i>
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24. FUNERAL DIRECTOR NAME <i>Charles W. Burrier, Jr., Sykesville, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>JAN 23 1986</i>	25b. REGISTRAR'S SIGNATURE <i>G. H. Davidson-Rodgers</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



050103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605243

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) HENRY WILLARD NEWELL			2a DATE OF DEATH MONTH DAY YEAR 02 13 86			2b HOUR 1217 PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 08 25 05		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD.			
10 CITY OR TOWN OF DEATH FREDERICK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FREDERICK MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD		13b COUNTY FREDERICK		13c CITY OR TOWN FREDERICK		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 601 Wyngate Dr., 21701	
14 FATHER'S NAME FIRST MIDDLE LAST WILLARD ALLEN NEWELL				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMIE TUPPER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17 INFORMANT ADDRESS David W. Newell Muscatine, Iowa					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>MASSIVE BRONCHOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>LEFT PARIETAL LACERATION INFARCT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>1 hr</u> <u>4 days</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

STATUS POST NEPHRECTOMY FOR PYONEPHROSIS

19a DATE OF OPERATION 01/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PYONEPHROSIS		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>02-10</u> , 19 <u>86</u> , to <u>02-13</u> , 19 <u>86</u> , that (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> lost saw the deceased alive on <u>02-13</u> , 19 <u>86</u> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.							
22a. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 02/13/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIO MENACA				22e. ADDRESS 516 TRAIL AVE, FREDERICK, MD 21701			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/14/86		23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SMITHSBURG WASHINGTON MD	
24 FUNERAL DIRECTOR NAME G. Douglas Stauffer				25a. DATE REC'D. BY REGISTRAR FEB 14 1986		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and, if required, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



055069

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 5 2 4 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARGARET Edith Nicodemus</b>			2a DATE OF DEATH MONTH DAY YEAR <b>2/15/86</b>			2b HOUR <b>0345M</b>			
3 SEX <b>F</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>APR 9 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b> MD			
10 CITY OR TOWN OF DEATH <b>FREDERICK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEKEEPER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b> COUNTY <b>FREDERICK</b> CITY OR TOWN <b>LIBERTYTOWN</b>				13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c STREET ADDRESS / ZIP CODE <b>21762</b> <b>12119 LIBERTYTOWN RD.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES F BOWERS</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA ETZLER</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b SOCIAL SECURITY NO. <b>216-46-8336</b>		17 INFORMANT ADDRESS <b>ELIZABETH CRUM-FREDERICK</b> <b>21701 MD</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2 13 56</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AL- WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>804 Tall House Ave Unionville MD</b>				
22a I certify that (I) (this hospital) attended the deceased from <b>2/14 1986</b> to <b>2/15 1986</b> that (I) (we) lost saw the deceased alive on <b>2/14</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b SIGNATURE <b>Casper E. Clinch</b> DEGREE <b>MD</b>						22c. DATE SIGNED <b>2/15/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Casper E. Clinch</b>						22e ADDRESS <b>804 Tall House Ave</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>2-17-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LINGANORE</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>UNIONVILLE MD</b>		
24 FUNERAL DIRECTOR NAME <b>D. Hartzler, Libertytown Md</b> ADDRESS						25a DATE REC'D. BY REGISTRAR <b>FEB 20 1986</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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White  
FREDERICK

1900-1901

1902-1903

1904-1905

1906-1907

1908-1909

1910-1911

1912-1913

1914-1915

052201

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 5 2 4 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Laura O. PFALZGRAF</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>February 8, 1986</b>		2b. HOUR <b>5:00P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 4, 1896</b>	
7a. BIRTHPLACE (COUNTRY) <b>Canada</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>89</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Home</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Orpin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Harris</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>237-06-4476</b>		17. INFORMANT NAME ADDRESS <b>Mrs. Georgene Smith 243 East 2nd St. Frederick, Md. 21701</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ischemic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Atrial fibrillation - Cerebrovascular disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>many years</b> 19 to <b>2/8/86</b> 19 that <b>we</b> (we) last saw the deceased alive on <b>2/8/86</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Austin Pearre, Jr.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/10/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Austin A. Pearre, Jr.</b>		22e. ADDRESS <b>804 Toll House Ave., Frederick, Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 12, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Piney Grove Cemetery</b>	
		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Swannanoa, Buncombe, N. C.</b>			
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>		25. DATE RECEIVED BY REGISTRAR 26. REGISTRAR'S SIGNATURE <b>106 East Church St., Frederick, Md. 21701</b> <b>FEB 13 1986</b> <b>J. Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner be notified at once.

BP

0-22-1

RECEIVED  
FEB 14 1962

MAIL ROOM

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows]

100-441110-100  
FEB 14 1962  
[Illegible text follows]



051134

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05246

1. DECEASED NAME (TYPE OR PRINT) Kenneth Leon Poole						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 15 1986		2b. HOUR 2300	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 - 12 - 44	6. AGE (IN YEARS) LAST BIRTHDAY 41 YRS.	7. IF UNDER 1 YR MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 15 1986		7d. HOUR 2300	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County MD			
10. CITY OR TOWN OF DEATH Union Bridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9017 Walnut Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Excavating	
13a. STATE MD						13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge	
14. FATHER'S NAME FIRST MIDDLE LAST Kenneth Densen Poole						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Esworthy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215 42 2793		17. INFORMANT Mrs. Karen L. Poole Union Bridge, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G-S-W Chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2 15 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted G-S-W Chest				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION 9017 Walnut Street Frederick County Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Robert J. Thomas, M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		DATE SIGNED 2-11-86	
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.			ADDRESS 812 Toll House Ave. Frederick, Md. 21701						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-20-86		23c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY		23d. LOCATION CITY OR TOWN MT. AIRY		23e. COUNTY FREDERICK	
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Sykesville, MD 21784		25a. DATE REC'D. BY REGISTRAR FEB 18 1986		25b. REGISTRAR'S SIGNATURE			

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041149

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lillian Irene RAUSCH</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>02-06-86</b>		2b. HOUR <b>8:02am</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 15 1917</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK MD.</b>			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Northampton Manor</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>HEALTH</b>		13a. STREET ADDRESS / ZIP CODE <b>10171 Crestview Dr., 21701</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE HARTUNG</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA STEWART</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-22-8423</b>		17. INFORMANT ADDRESS <b>Frederick, MD 21701</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b>		(b) <b>PULMONARY METASTASES FROM OSTEOGENIC</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 DAY</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c) <b>SARCOMA</b>		<b>20 MONTHS</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>STROKE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>January</b> , 19 <b>82</b> , to <b>FEB 6</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>FEB 4</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph Ashwal MD</b>				22c. DATE SIGNED <b>2-6-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Ashwal</b>				22e. ADDRESS <b>4 W 7th ST. FREDERICK MD 21701</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/8/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM. BALTIMORE</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE BALTIMORE MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>G. Douglas Stauffer 1621 Opossumtown Pike, Frederick, MD</b>			

MEDICAL CERTIFICATION

35

100

20

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 25a. DATE REC'D BY REGISTRAR  
 25b. REGISTRAR'S SIGNATURE  
**FEB 06 1986**

CELL 40

11/23/12

2012-11-23 11:11:11

11/23/12

11/23/12



057154

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sadie Sarah Ravgiala			2a. DATE OF DEATH MONTH DAY YEAR 2 21 1986			2b. HOUR 12:45p						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 2 1998		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.						
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 111 S. Potomac St. 21713		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES C. SAWDON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BLANCHE STEVENS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS William H. Ravgiala, Sharpsburg, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Osteomyelitis, right foot</u>										<u>6 months</u>		
(c) <u>Peripheral Vascular disease</u>										<u>2 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/86</u> to <u>Feb. 21</u> 19 <u>86</u> , that (I) <del>last</del> saw the deceased alive on <u>Feb. 20</u> 19 <u>86</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was not</del> (did not) view the body after death.												
22b. SIGNATURE <u>Bernard O. Thomas Jr.</u>					DEGREE <u>MD.</u>					22c. DATE SIGNED <u>2/22/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. B. O. Thomas, Jr.</u>					22e. ADDRESS <u>228 N. Market St., Frederick, MD 21701</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>2/25/86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Port Huron St. Clara MI</u>				
24. FUNERAL DIRECTOR NAME <u>G. Douglas Stauffer</u>					25a. DATE REC'D. BY REGISTRAR <u>FEB 24 1986</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>				

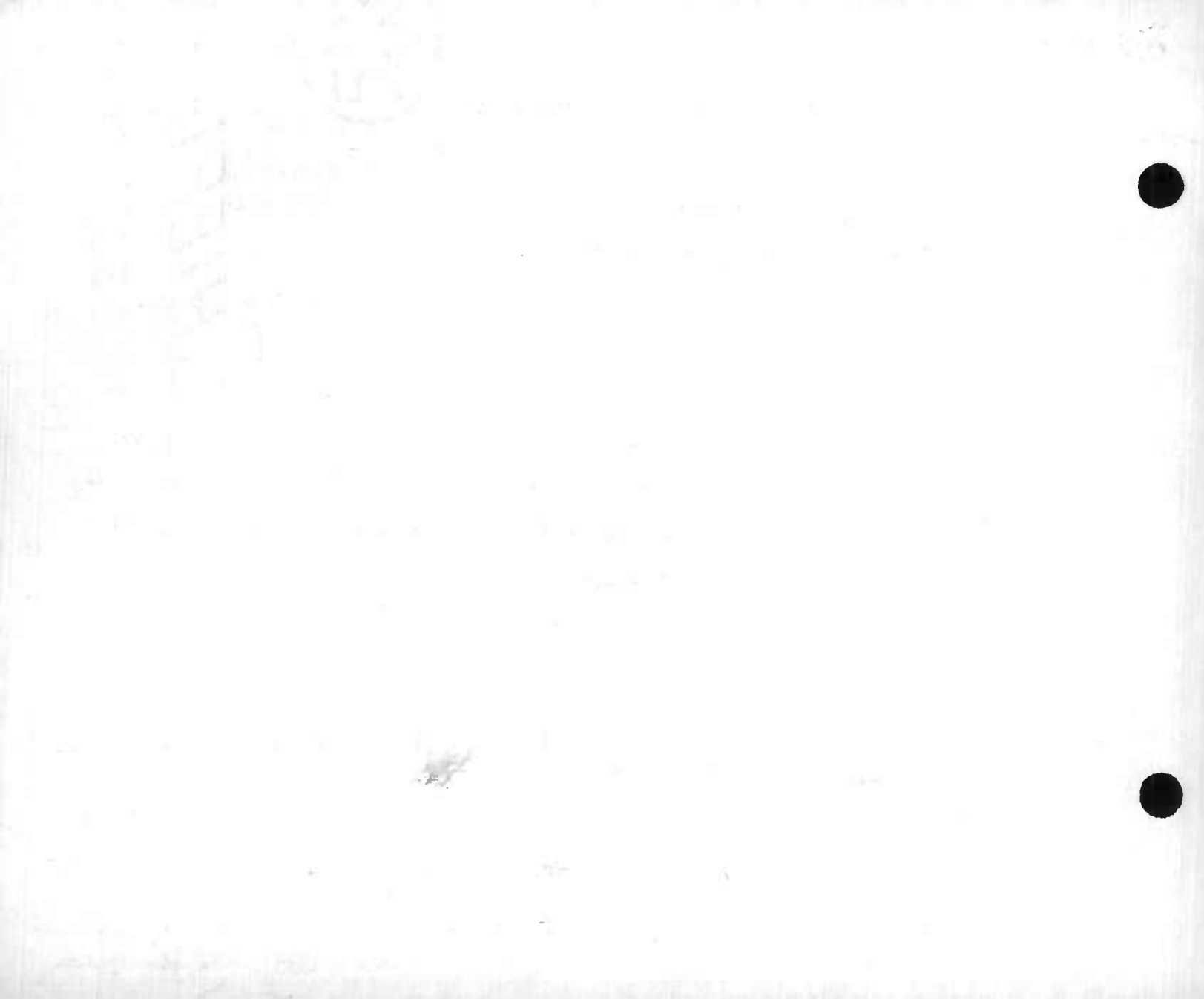
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP



051212

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

05249

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH CAMELIA REED</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 6 86</b>		2b. HOUR <b>2:50 A M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 27, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>FREDERICK, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOME FOR THE AGED</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmer L. SHANNON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAMIE KEIL</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No - - - -</b>			
16b. SOCIAL SECURITY NO. <b>214-74-3234</b>		17. INFORMANT ADDRESS <b>Home For The Aged, 115 Record Street Frederick, Md. 21701</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA Cerebral vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from <b>June 2/4</b> , 19 <b>85</b> , to <b>Present</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death.)							
22b. SIGNATURE <b>Le Roy T. Davis</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/6/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Leroy T. Davis, M.D.</b>		22e. ADDRESS <b>801 Toll House Ave., Fred. Md. 21701</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 7, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery Baltimore</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>Michael Reeney Basford P.A. Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>Feb 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Davis</b>			
26. ADDRESS <b>106 East Church St., Fred. Md. 21701</b>							

BP





052187

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 5 0

REG. NO.

1 DECEASED NAME (TYPE PRINTS) <b>Theodore Carl Jacob REUTHER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 6, 1986</b>			2b HOUR <b>9:05 AM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 16, 1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	
13a STATE <b>Maryland</b>			13b CITY OR TOWN <b>Frederick</b>		13c CITY OR TOWN <b>Frederick</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Valentine Reuther</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Stocker</b>			13e STREET ADDRESS / ZIP CODE <b>7079 Catalpa Dr., 21701</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17 INFORMATION ADDRESS <b>Mrs. Anna Reuther 7079 Catalpa Drive Frederick, Md. 21701</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration pneumonia &amp; changes</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinsons disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>3 years</b> <b>6 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Parkinsons Disease &amp; Renal failure</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from <b>2/6</b> 19 <b>86</b> to <b>Present</b> , that (I) (we) last saw the deceased alive on <b>2/6</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) could not view the body after death.)									
22b SIGNATURE <b>LeRoy T. Davis</b> M.D.				22c ADDRESS <b>801 Toll House Ave., Frederick, Md. 21701</b>		22d DATE SIGNED <b>2/6/86</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Feb. 10, 1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Wheeling, Ohio, West Virginia</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>Smith, Keeney &amp; Basford Funeral Home 106 East Church St., Frederick, Md. 21701</b>				25a DATE REC'D. BY REGISTRAR <b>FEB 13 1986</b>		25b REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 05251  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hattie Case Ricketts			2a. DATE OF DEATH MONTH DAY YEAR February 13, 1986			2b. HOUR 5:45p M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 11, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Redland Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County Maryland MD.			
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 160 J Willowdale Drive Frederick, Maryland 20701	
14. FATHER'S NAME FIRST MIDDLE LAST James Joseph Case				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Pennyfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-28-6968		17. INFORMANT W.T. Ricketts (Son) 1040 Lower Pindell Road Lothian, Maryland 20711					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease (CVA.)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11/85</u> to <u>2/13/86</u> , that (I) saw the deceased alive on <u>2/13/86</u> above, (I) (did not) view the body after death, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>Robert L. Kaufmann, MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/13/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Kaufmann						22e. ADDRESS 804 Tollhouse Avenue Frederick, Maryland 21701			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE February 17, 1986		23c. NAME OF CEMETERY OR CREMATORY Darnestown Presbyterian Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Darnestown, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes P.A. 300 West Montgomery Avenue Rockville, Md 20850						25a. DATE REC'D. BY REGISTRAR FEB 20 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, except a may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SARA M. RICKETTS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-6-86</b>			2b. HOUR <b>10:50<sup>P</sup><sub>M</sub></b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 17 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Citizens Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>R#6 Box 5517, 21701</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Matthews</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel Newman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>n/a</b>		17. INFORMANT <b>Seymour Stern</b>		ADDRESS <b>Frederick, MD</b> <b>118 W. Church St.,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASX/D</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>T. Stuber</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2-7-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/10/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gard.</b>		23d. LOCATION CITY OR TOWN <b>Frederick</b>		COUNTRY <b>Frederick</b> STATE <b>MD</b>	
24. FUNERAL DIRECTOR NAME <b>G. Douglas Stauffer</b> ADDRESS <b>1621 Opossumtown Pike, Frederick, MD</b>						25a. DATED BY REGISTRAR <b>FEB 14 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	05253						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Audrey E. Ridenour										2a. DATE KNOWN OF DEATH ESTIMATED	2b. HOUR						
3. SEX F	4. RACE W	5. DATE OF BIRTH (MONTH DAY YEAR) Jul. 28 1931	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD	8. MONTH DAY YEAR 2 21 86	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick		10. CITY OR TOWN OF DEATH Thurmont		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 W. Main Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory worker	12b. KIND OF BUSINESS OR INDUSTRY Shoe				
13a. STATE MD		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 W. Main		21788							
14. FATHER'S NAME FIRST MIDDLE LAST George Gebhart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Hahn				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 187 24 0646		17. INFORMANT Larry Glass		18. ADDRESS 15611 Kelbaugh Rd. Thurmont, MD. 21788	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic asthma</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Robert J. Thomas</u>				TITLE (SPECIFY) Deputy				DATE SIGNED <u>2/24/86</u>									
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.				ADDRESS 812 Toll House Ave. Frederick, Md. 21701													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/24/86		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Gettysburg Adams Pa.							
24. FUNERAL DIRECTOR NAME Robert A. Myers				ADDRESS 91 Willis St. Westminster, MD				25a. DATE REC'D. BY REGISTRAR MAR 03 1986				25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05254

1. DECEASED NAME (TYPE OR PRINT) <b>Steven L. Rogge</b>			2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 2-26 19 86			2b. HOUR M 12:10 P. M.		
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>02</b> DAY <b>18</b> YEAR <b>55</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>31</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <b>3</b> - <b>2</b> 19 86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County,</b> MD			10. CITY OR TOWN OF DEATH <b>FREDERICK</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>170 west - rest stop - truck</b>		
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE <b>INDIANA</b> 12c. CITY OR TOWN <b>CRAWFORD</b> 12d. CITY OR TOWN <b>MARENGO</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Rt. 2 Box 199</b>			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCKER</b>		
12f. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>			14. FATHER'S NAME FIRST <b>HERMAN</b> MIDDLE <b>D.</b> LAST <b>ROGGE</b>			15. MOTHER'S MAIDEN NAME FIRST <b>CAROLINE</b> MIDDLE <b>J.</b> LAST <b>CONRAD</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>285-54-8393</b>			17. INFORMANT <b>JO-ANN W. ROGGE, Rt. 2 Box 199</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Renal Disease</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>3-3-86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/6/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GRACELAND MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>NEW ALBANY FLOYD IND</b>	
24. FUNERAL DIRECTOR NAME <b>G. DOUGLAS STAUFFER</b> ADDRESS <b>1621 Opossumtown Pike, Frederick, MD</b>			25a. DATE REC'D BY REGISTRAR <b>MAR 6 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 5 5

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		M	
Carrie Ethel ROMSBURG		February 27, 1986			
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	85	MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Pennsylvania		U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH	
Frederick		North Hampton Nursing Home		Frederick County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Frederick		North Hampton Nursing Home		Homemaker	
12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS / ZIP CODE		13b INSIDE CITY LIMITS?	
Home		236 Carroll Parkway 21701		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Bernard J. Lichty		Katherine Sheeler		No	
16b SOCIAL SECURITY NO.		17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) (b) (c)	
212-28-2774		Mrs. Violet Fogle 613 Biggs Ave. Frederick, Md. 21701		Alzheimer's disease	
				Congestive heart failure	
				5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 70 to 2/27/86 that (I) (we) last saw the deceased alive on 2/26/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
Robert S. Hughes		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/28/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Dr. Robert S. Hughes		700 Montclair Ave., Frederick, Md. 21701			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		March 1, 1986		Mount Olivet Cemetery Frederick, Frederick, Md.	
24 FUNERAL DIRECTOR'S NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Smith, Keeney-Basford Funeral Home		MAR 03 1986		John Davidson-Randall	
106 East Church St., Frederick, Md. 21701					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 5 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret Alice SEIPLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 16, 1986</b>		2b. HOUR <b>11:06a<sub>M</sub></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 12, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>51 East Partick Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Owner/Operator</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>51 East Patrick Street/21701</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Delaney Eckenrode</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hanna Clara Snider</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-16-0365</b>		17. INFORMANT ADDRESS <b>Charles D. Kiser, 1124 St. Anthony Street, Lewisburg, Pa. 17837</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic - valvular heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden death</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Generalized arteriosclerosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-6-54</b> , 19 <b>54</b> , to <b>2-17-86</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>1-13-86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rex R. Martin</i>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2-17-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Rex R. Martin, M.D.</b>		22e. ADDRESS <b>220 N. Market St., Frederick, Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 19, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>	
24. FUNERAL HOME NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	
106 East Church St., Frederick, Md. 21701					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove this certificate from the file and place it in the file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified of this.

February 16, 1988 11:00a

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 05257

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Glenn Carlton SHAFER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 7, 1986</b>		2b. HOUR <b>2:05 P.M.</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 2, 1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b> MD.		
10 CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5735 Shookstown Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Custodian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Board of Educa.</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>	13c. CITY OR TOWN <b>Frederick</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George Carlton Shafer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Toms</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-10-2133</b>		17 INFORMANT <b>Mrs. Lillian Shafer</b> ADDRESS <b>5735 Shookstown Rd. Frederick, Md. 21701</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Obstructive disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 d</b> <b>10-year</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 19 75</b> to <b>Feb 7 19 86</b> , that (I) (we) lost saw the deceased alive on <b>1/18 19 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Robert S. Hughes</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/10/1986</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert S. Hughes</b>		22e. ADDRESS <b>700 Mountclaire Ave., Frederick, Md. 21701</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 11, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>
24 FUNERAL DIRECTOR NAME <b>Smith, Keeney &amp; Basford Funeral Home</b> ADDRESS <b>106 East Church St., Frederick, Md. 21701</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 13 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Pendall</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP







071185

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 5 2 5 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Katharine Elizabeth SHAW			2a DATE OF DEATH MONTH DAY YEAR February 19, 1986		2b HOUR 5:30 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1909		
6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.		10 CITY OR TOWN OF DEATH Frederick		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home for the Aged		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b KIND OF BUSINESS OR INDUSTRY Domestic work				
13a STATE Maryland			13b COUNTY Frederick		13c CITY OR TOWN Frederick	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Elizabeth Shaw			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17 INFORMANT ADDRESS Home for the Aged, 115 Record Street, Frederick, Md., 21701		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A54D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>July 1975</u> to <u>Feb 1986</u> that (I) (we) lost <u>86</u> saw the deceased alive on <u>15 Feb 1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.						
22b SIGNATURE <u>Timothy Hickey</u> DEGREE				22c DATE SIGNED <u>2/21/86</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Timothy Hickey, Jr., M.D.				22e ADDRESS Parkview Medical Center, Frederick, Md. 21701		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Feb 21, 1986		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		
23d LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.		24 FUNERAL DIRECTOR Name <u>Smith, Keeney and Basford</u> Address <u>106 East Church St., Frederick, Md. 21701</u>				
25a DATE REC'D. BY REGISTRAR FEB 26 1986		25b REGISTRAR'S SIGNATURE <u>John Davidson-Randell</u>				

MEDICAL CERTIFICATION

279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

2:30 P.

January 12, 1966

Washington, D.C.

Mr. [Name]

Jan. 9, 1966

White

Mr. [Name]

Washington, D.C.

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Mr. [Name]

Washington, D.C.

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Mr. [Name]

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Mr. [Name]

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605259

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>LESTER EUGENE SINNER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 3, 1986</b>		2b HOUR <b>4:00 am</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>July 6, 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland Odd Fellows Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Route</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE <b>Maryland</b>	13b COUNTY <b>Frederick</b>	13c CITY OR TOWN <b>Frederick</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>400 North Street/ 21701</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Sinner</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Mae Lauer</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WWII 205-22-4719</b>		17 INFORMANT <b>2520 Anaconda Trail LaRue Stelene, Maitland, Florida</b>	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.V.A.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b SIGNATURE <i>T. F. Hickey</i>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c DATE SIGNED <b>2/4/86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. F. Hickey MD</b>		22e ADDRESS <b>Parkview Medical Center, Frederick, Md. 21701</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>Feb. 5, 1986</b>	23c NAME OF CEMETERY OR CREMATORY <b>Smithsburg Crematory</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Smithsburg, Washington, Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Smith, Keeney and Basford Funeral H.</b> <b>106 East Church Street, Frederick, Md. 21701</b>			25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE		

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP \_\_\_\_\_

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057121

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605260

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ALVIE WOODROW SMITH JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02/18/86</b>			2b. HOUR <b>7:10AM</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07/06/37</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>48</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b> MD.				
10 CITY OR TOWN OF DEATH <b>UNION BRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9009 B BESSIE CLEMSON RD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STONE PRODU</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>FREDERICK</b>		13c. CITY OR TOWN <b>UNION BRIDGE</b>		13d. INSIDE CITY LIMITS? <b>NO</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9009 B BESSIE CLEMSON R21791</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>ALVIE W. SMITH SR.</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENAORA SPARROW</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-34-2328</b>		17 INFORMANT ADDRESS <b>PRISCILLA R. SMITH 9009 B BESSIE CLEMSON RD</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUDDEN CARDIAC DEATH</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>LEFT VENTRICULAR DYSFUNCTION</b>								<b>2 YEARS</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b>								<b>2 YEARS</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PERIPHERAL VASCULAR DISEASE</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>4-25-84</b> to <b>2-18-86</b> , that (we) last saw the deceased alive on <b>1-23-86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>S. Kahan</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>2-18-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHERMAN KAHAN</b>					22e. ADDRESS <b>4 W. 7th ST. FREDERICK, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>DEBURIAL HARTZLER</b>			23b. DATE <b>02/21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LIBERTY TOWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LIBERTYTOWN FREDERICK MD</b>			
24. FUNERAL DIRECTOR NAME <b>H. O. Santles</b>					ADDRESS <b>Libertytown, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1986</b>			
					25b. REGISTRAR SIGNATURE					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the following pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



052093

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605261

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE William SMITH</b>			2a. DATE OF DEATH MONTH <b>February</b> DAY <b>10</b> YEAR <b>1986</b>		2b. HOUR <b>3:30 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>May</b> DAY <b>15</b> YEAR <b>1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farming</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>New Midway</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>12337 Legore Road/ 21775</b>	
14. FATHER'S NAME FIRST <b>Earl</b> MIDDLE <b>Leroy</b> LAST <b>Smith</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Elsie</b> MIDDLE <b>May</b> LAST <b>Nichols</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-10-4865</b>	17. INFORMANT <b>12337 Legore Road/ Box 38</b> <b>Mrs. Catherine V. Smith, New Midway, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>TERMINAL ACUTE MYELOGENOUS LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS, HYPERTENSIVE HEART DISEASE</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-8</b> , 19 <b>86</b> , to <b>2-10</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>2-9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Arthur S. Mawds, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>2/10/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR S. MAWDS, M.D.</b>		22e. ADDRESS <b>GREEN VALLEY CENTER, MOUNTAIN VIEW, MD. 21770</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Buried</b>	23b. DATE <b>Feb 13, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Frederick, Md.</b> COUNTY <b>Frederick, Md.</b> STATE		
24. FUNERAL HOME <b>Smith, Keeney &amp; Basford Funeral Home</b>		25. REGISTRAR'S SIGNATURE <b>FEB 18 1986</b>			
106 E. Church Street, Frederick, Md. 21701					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-removable portion of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.







052058

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Melvin Joseph Sollod			2a. DATE OF DEATH MONTH DAY YEAR 2 5 86			2b. HOUR 8:53 A.M.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11/11/13		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.			
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Drug Store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b. CITY OR TOWN Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Nathan Sollod			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None			17 INFORMANT Mrs. Mary Sollod, 5597 Teakwood Court, Frederick, Md. 21701			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANINE BIT</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>Dec 1985</u> to <u>Feb 5 1986</u> , that (1) (we) lost saw the deceased alive on <u>Dec 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael Behre			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Behre			22e. ADDRESS Church & Franklin St., Middletown, Md. 21769						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Maryland		
24 FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home			25 DATE REC'D BY REGISTRAR Feb 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				
106 East Church Street, Frederick, Md. 21701									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8605263

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MAMIE FRANCES SOPER SOPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 16 86</b>		2b. HOUR <b>10:30 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 20, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Frederick</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7928 Devilbiss Bridge Road 21701</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Edward Stewart</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Ridgeway</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-24-8641</b>		17. INFORMANT <b>Mrs. Marie Bish</b> ADDRESS <b>7928 Devilbiss Bridge Road Frederick, Maryland 21701</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Acute calculus cholecystitis</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> <b>86</b> to <b>2/16</b> <b>86</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Robert J. Thomas MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/16/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert J. Thomas, MD</b>				22e. ADDRESS <b>812 Toll House Avenue, Frederick, Md. 21701</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/19/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Point of Rocks, Frederick, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>R. E. Dailey &amp; Son, P.A.</b>				25a. DATE REC'D BY REGISTRAR <b>FEB 21 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the date, time, place, and nature of the event.

BP

002440



052238

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

REG. NO.

05264

1. DECEASED NAME (TYPE OR PRINT) <b>Bernard Calvin Staley</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>2</b> YEAR <b>1986</b>			2b. HOUR <b>2318</b> M								
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>June</b> DAY <b>2</b> YEAR <b>1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Board of Educat.</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Frederick</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>252 South Carroll St., 21701</b>		
14. FATHER'S NAME FIRST <b>Bernard</b> MIDDLE <b>C.</b> LAST <b>Staley</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Della</b> MIDDLE <b></b> LAST <b>McBride</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO (IF YES, GIVE YEAR OR DATES) <b>1942-1945</b>				17. INFORMANT <b>Mrs. Ann M. Keeney</b> ADDRESS <b>24 East South Street Frederick, Md. 21701</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **resp arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) **extensive pancreatic**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Coronary**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**4 hrs**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/86</b> to <b>2/2</b> 19 <b>86</b> . I saw the deceased alive on <b>2/2/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. P. Gregory Rausch</b>				DEGREE <b>Dr.</b>		22c. DATE SIGNED <b>2/2/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. P. Gregory Rausch</b>				22e. ADDRESS <b>4 West Seventh St., Frederick, Md. 21701</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 5, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Frederick</b> COUNTY <b>Frederick</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Smith, Keeney and Basford Funeral Home</b> ADDRESS <b>106 East Church St., Frederick, Md. 21701</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1986</b>				25b. REGISTRAR'S SIGNATURE <b>J. A. Davidson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Provisional County

Distance

Distance (miles)

Provisional County

Distance

Distance

Distance

Distance

Provisional County  
Distance (miles)

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Distance (miles)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 05265  
REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>JAIROS WALL STATION, SR.</b>		2a DATE OF DEATH MONTH DAY YEAR <b>2/18 2/18/86</b>		2b HOUR <b>0156 M</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>January 3, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick</b> MD.	
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret/Serv. Sta. Owner</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Maryland</b>		13b COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Frederick</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Lewis Staton</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sallie Wall</b>		13e STREET ADDRESS / ZIP CODE <b>429 South Market St. 21701</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>233-28-1843A</b>		17 INFORMANT ADDRESS <b>Mrs. Audrey Staton Frederick, Md. 21701</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute stroke</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 day</b> <b>11 day</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/7, 1986</b> to <b>2/18, 1986</b> , that (I) (we) last saw the deceased alive on <b>2/7, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Robert S. Hughes</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/18/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert S. Hughes, MD PA</b>				22e ADDRESS <b>700 Montclair Ave., Frederick, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Robert E. Dailey &amp; Son, P. A.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 26 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John E. ...</b>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 05266	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROLAND		MIDDLE GUY		LAST STOVER		2a. DATE OF DEATH MONTH DAY YEAR 2/18/86		2b. HOUR 0035 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 09/11/14		6. AGE (IN YEARS LAST BIRTHDAY) 71		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK					
10. CITY OR TOWN OF DEATH FREDERICK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FREDERICK MEMORIAL HOSPITAL						12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) MASON		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD FREDERICK KEYMAR TOWN		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. 11039 ROCKY RIDGE RD. 21757							
14. FATHER'S NAME CHARLES A. STOVER				15. MOTHER'S MAIDEN NAME MATTIE KRISE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 214-16-0142		17. INFORMANT NORMA R. STOVER				17b. ADDRESS 11039 ROCKY RIDGE RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>METASTATIC RENAL CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>ANEMIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION 5 yrs ago		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left Renal Carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 18</u> , 19 <u>86</u> to <u>Feb 18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Feb 18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert D. Crouch</u>				DEGREE MD				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT D. CROUCH, MD				22e. ADDRESS 806 TOLL HOUSE AVE, FREDERICK, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02/21/86		23c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEMETERY		23d. LOCATION WOODSBORO FRED. MD					
24. FUNERAL DIRECTOR D. D. HARTZLER				WOODSBORO, MD				25a. DATE REC'D. BY REGISTRAR FEB 24 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Hendell</u>	

BP

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DMOD MARY FILLID



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 05267  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
FIRST MIDDLE LAST LAURA FRANCES STRUBE			MONTH DAY YEAR February 14, 1986			9:21 PM		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female	Caucasian	MONTH DAY YEAR June 30, 1894	91 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA				Frederick, MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Frederick	Citizens Nursing Home			Retired Hotel Clerk			None	
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE
Maryland			Frederick	Frederick	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			282 Dill Avenue 21701
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST William Thomas Price				FIRST MIDDLE LAST Algerine Turner				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
Yes			WW I		282 Dill Avenue Mrs. Robert M. Staley, Jr. Frederick, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) <u>Cardiac Arrest</u> 8583 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute subacute Cardiac Vascular Disease</u> 15 years (c) <u>Degenerative</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Degenerative</u>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK								
22a I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>85</u> to <u>Feb. 14</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>Feb 14</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b SIGNATURE <u>B. O. Thomas Jr.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>2/17/86</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. O. Thomas, Jr., M.D.						22e ADDRESS 228 N. Market Street, Frederick, Md. 21701		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial			2/17/86		Mt. Olivet Cemetery		Frederick, Frederick, Maryland	
24 FUNERAL DIRECTOR <u>R. E. Bailey &amp; Son, P. A.</u>						25a DATE REC'D. BY REGISTRAR FEB 21 1986		
ADDRESS Frederick, Md.						25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If page 2 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified.

1 JAN 11 10 100 200

*[Faint handwritten signature or initials]*

053006

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP \_\_\_\_\_  
 DHMH - 17  
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 05268	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WAHILLA O. TWOHIG										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 2 23 1986	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 27 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 23 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD	
10. CITY OR TOWN OF DEATH NR. FREDE RICK				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7731 BRIDLE PATH CIRCLE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
13a. STATE MARYLAND				13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7731 BRIDLE PATH CIRCLE/21701	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS VAUGHN CALLAHAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE FAWBAUSH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS VICTORIA DAHMER 7731 BRIDLE PATH CIRCLE FREDERICK, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TB PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Robert J. Thomas</u>				TITLE (SPECIFY) Deputy				DATE SIGNED 2-24-86			
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.				ADDRESS 812 Toll House Ave. Frederick, Md. 21701							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/26/86		23c. NAME OF CEMETERY OR CREMATORY JEFFERSON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE JEFFERSON GREENE PA			
24. FUNERAL DIRECTOR NAME D. D. HARTZLER						ADDRESS WOODSBORO, MD		25a. DATE REC'D. BY REGISTRAR FEB 26 1986		25b. REGISTRAR'S SIGNATURE <u>June Antecoon-Henderson</u>	

MEDICAL CERTIFICATION

28 20 2

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052235

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

05269

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Shirley ANN WARFIELD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>2-1-86</b>		2b. HOUR <b>0314M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 12, 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Frederick</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13e. STREET ADDRESS / ZIP CODE <b>1776 Springfield Lane/21701</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Luther Putman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Frances Nusbaum</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-38-0629</b>		17. INFORMANT ADDRESS <b>Bernard T. Warfield, 1776 Springfield Lane, Frederick, Md. 21701</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>resp arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>extensive nodular liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cell lymphoma</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/30</b> , 19 <b>86</b> to <b>2/1</b> , 19 <b>86</b> that (we) last saw the deceased alive on <b>1/31</b> , 19 <b>86</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P. Gregory Rausch, MD.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>2/1/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. Gregory Rausch, MD.</b>				22e. ADDRESS <b>4 West 7th St., Frederick, Maryland 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 4, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, MD.</b>	
24. FUNERAL DIRECTOR'S NAME <b>Smith, Keeney and Basford Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John A. ...</b>	
106 East Church St., Frederick, Md. 21701							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





071184

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 05270

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL KENNETH WEIGEL</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Feb. 18, 1986</b>		2b. HOUR <b>11:15 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Cauca.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 12, 1911</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>75 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD <b>2 18 1986</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Game Protector</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Frederick</b>	13c. CITY OR TOWN <b>Thurmont</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel A. Weigel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Ifft</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>211-01-5071A</b>		17. INFORMANT ADDRESS <b>506 E. Main St.</b> <b>Mrs. Hazel V. Weigel Thurmont, Md. 21788</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Nicholas' Bronchitis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Robert J. Thomas</b>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER DATE SIGNED <b>2/19/86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Robert J. Thomas, MD</b>		ADDRESS <b>812 Toll House Ave. Fred. Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/21/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resthaven Mem. Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 26 1986</b>		23f. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
24. FUNERAL HOME TO HAVE NAME <b>R. E. Dailey &amp; Son, P. A.</b>		ADDRESS <b>615 E. Main Street</b>		CITY OR TOWN <b>Thurmont, Md.</b>	



UNION

MINERAL

RECEIVED

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066130

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 05271  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MARIANA KATHERINE WETZEL</b>		2a. DATE OF DEATH MONTH <b>2</b> DAY <b>8</b> YEAR <b>86</b>		2b. HOUR <b>2:30 AM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH MONTH <b>05</b> DAY <b>07</b> YEAR <b>01</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>FREDERICK</b> MD.	
10 CITY OR TOWN OF DEATH <b>FREDERICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FREDERICK MEM HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>FREDERICK</b>	13c. CITY OR TOWN <b>THURMONT</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>M.</b> LAST <b>RODDY</b>		15. MOTHER'S MAIDEN NAME FIRST <b>LAURA</b> MIDDLE <b>G.</b> LAST <b>ORNDORFF</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>213-50-9284</b>	17. INFORMANT ADDRESS <b>16010 ST. ANTHONY RD. THURMONT, MARYLAND 21788</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>COMPLETE HEART BLOCK</b>				<b>15 min</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b>				<b>48 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>NON KETOTIC DIABETIC COMA</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>2/8/86</b> 19 <b>86</b> to <b>2/8</b> 19 <b>86</b> , that (I) (the hospital) last saw the deceased alive on <b>2/8</b> 19 <b>86</b> , and that in (my) (the hospital) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did not) view the body after death.				
22b. SIGNATURE <b>Mark P. Rubin</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/8/86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK P. RUBIN</b>		22e. ADDRESS <b>5699 BRIARCREVE CT FREDERICK MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2/11/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANTHONY SHRINE</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>EMMITSBURG FREDERICK MD.</b>	
24. FUNERAL DIRECTOR NAME <b>William D. Bailey</b> <b>ROBERT E. DAILEY &amp; SON</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 21 1986</b>	25. REGISTRAR'S SIGNATURE <b>John Davidson Randall</b>	

MEDICAL CERTIFICATION

35  
64  
35  
100

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



065168

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86  
REG. NO.

05272

1 DECEASED NAME (TYPE OR PRINT) <b>MATILDA T THOMPSON WHITE</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 21, 1986</b>			2b HOUR <b>7:35A<sub>M</sub></b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 1, 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>84</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Frederick</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Campbell Thompson</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Barnard</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b SOCIAL SECURITY NO. <b>220-46-4616</b>			17 INFORMANT <b>Mrs. William J. Pauley 699 Second St. Beaver, Pa. 15009</b>						
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Alzheimer's Disease - Diverticulitis</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the Deceased from <b>1/17/86</b> , 19____, to <b>2/21/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/20/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Austin A. Pearre, Jr</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/21/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Austin A. Pearre, Jr</b>						22e. ADDRESS <b>804 Toll House Ave., Frederick, Md. 21701</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb 25, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beallsville, Montgomery, Md.</b>		
24 FUNERAL DIRECTOR'S NAME <b>Smith, Keeney &amp; Basford Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
106 East Church St., Frederick, Md. 21701						FEB 28 1986			

MEDICAL CERTIFICATION

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 is not marked, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NOTION 2000

WIKI

THE UNIVERSITY OF CHICAGO  
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064107

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6  
REG. NO.

0 5 2 7 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROSE ELLA WHITE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 19, 1986</b>		1:00 P. M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 24, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <b>Md. Fred. Middletown</b>		13b. COUNTY <b>Md.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>62 Boileau Ct. 21769</b>	
14. FATHER'S NAME FIRST MIDDLE <b>FREDERICK ABRAMS</b>		15. MOTHER'S MAIDEN NAME MIDDLE <b>ANNA UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>028-20-8036D</b>		17. INFORMANT ADDRESS <b>Hazel Decaro Middletown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I; OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>many years</b> , 19 <b>1986</b> , to <b>2/19/86</b> , 19 <b>1986</b> , that (I) (we) last saw the deceased alive on <b>about month 8</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Austin Pearre Jr.</b>		DEGREE <b>Dr. Austin Pearre Jr.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/19/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Austin Pearre Jr.</b>		22e. ADDRESS <b>Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 24, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bellingham Mass.</b>	
24. FUNERAL DIRECTOR <b>Thompson Funeral Home Middletown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Thompson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filing in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 when any injury, or other traumatic event, the medical examiner must be notified and present.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the permit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

 FOR  
 1- STATE  
 REGISTRAR

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

8 5 0 5 2 7 4

1. DECEASED NAME (TYPE OR PRINT) Sister Rose Wilkinson			2a. DATE OF DEATH MONTH DAY YEAR Feb. 3, 1986			2b. HOUR 3:20 p.m.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.					
10. CITY OR TOWN OF DEATH Emmitsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michael, Emmitsburg, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Dgtrs. of Charity			
13a. STATE Md.			13b. COUNTY Frederick		13c. CITY OR TOWN Emmitsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 333 S. Seton Avenue 21727		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Wilkinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edithe Corde							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 214-54-5796M		17. INFORMANT ADDRESS Sr. Josephine-Villa St. Michael, Emmitsburg						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Upper Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Major Cerebrovascular Accident											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alan Carroll MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4 Feb. 86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Carroll, M.D.						22e. ADDRESS S. Seton Ave. Emmitsburg, MD 21727					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5 Feb 86		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's			23d. LOCATION CITY OR TOWN COUNTY STATE Emmitsburg, Frederick, MD			
24. FUNERAL DIRECTOR NAME ADDRESS Skiles Funeral Home, Emmitsburg, MD 21727						25a. DATE REC'D. BY REGISTRAR FEB 07 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 2 7 5

1 DECEASED NAME (TYPE OR PRINT) NORMAN WALTER WILSON			2a DATE OF DEATH MONTH DAY YEAR 02/18/86			2b HOUR 955 AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 11/17/88		6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD.			
10 CITY OR TOWN OF DEATH FREDERICK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b KIND OF BUSINESS OR INDUSTRY DAIRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE MD		13b COUNTY FREDERICK		13c CITY OR TOWN FREDERICK		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS CITIZENS NURSING HOME 21701	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN W. WILSON				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DESOTA Mc CUBBINS					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-7161		17 INFORMANT ADDRESS BRUNSWICK, MD 21716 29 EAST B. ST.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD &amp; CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Degenerative arthritis spine</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>86</u> , to <u>2/18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>James E. Stoner, MD</u>						DEGREE MD		22c DATE SIGNED 2/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. STONER, MD						22e ADDRESS WALKERSVILLE, MD 21793 P.O. BOX 215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 02/20/86		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FREDERICK FREDERICK MD		
24. FUNERAL DIRECTOR NAME D. D. HARTZLER						ADDRESS WOODSBORO		25a. DATE REC'D. BY REGISTRAR FEB 24 1986	
						25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and keep pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 05276  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GAIL DELAUTER WISE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 11, 1986</b>			2b. TIME OF DEATH HOURS MIN. <b>9:05 A.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 9, 1914</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. <b>71</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co.</b>			10. MD.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meredian Nursing Center</b>				12. TYPE OF WORK FOR MOST OF WORKING LIFE <b>executive ass't.</b>			13. INDUSTRY <b>U.S. Dept. Defense</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Middletown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>214 Lombardy Ct. 21769</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert L. Wise</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Norma Delauter</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>W. W. II Yes</b>			16b. SOCIAL SECURITY NO. <b>214-10-3637</b>		17. INFORMANT <b>Michael Locke</b>			ADDRESS <b>Frederick, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congest Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Heart Disease, 2nd infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>12 Hours</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I (1) (is) hospital attended the deceased from <b>1986</b> to <b>2/11/86</b> , that I (1)(we) last saw the deceased alive on <b>2/11/86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1)(we) (did and not) view the body after death.										
22b. SIGNATURE <b>Robert L. Kavenmann, MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/14/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ROBERT L. KAVENMANN</b>			22e. ADDRESS <b>FREDERICK MD 21701</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 14, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Middletown Fred. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Thompson Funeral Home</b>			ADDRESS <b>Middletown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 25 1986</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Davidson</b>			

BP

Feb. 11, 1966

Mr. J. A. White

White

White

U.S.A.

U.S.A.

National Housing Center

National Housing Center

Mr. J. A. White

Mr. J. A. White

Albert E. White

Robert

Deputy

W. M. White

W. M. White - 3037

Production, Inc.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. Q. 5 2 7 7

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Joshua		MIDDLE Travis		LAST ZIMMERMANN		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 2/20/		DAY 1986		YEAR 1986		2b. HOUR 9:50	
3. SEX Male		4. RACE Oriental		5. DATE OF BIRTH MONTH May 31, 1985		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 8 19		IF UNDER 1 YR. MONTHS 8 19		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 2/ 20/19 86		DAY 19 86		YEAR A M	
6. BIRTHPLACE (STATE OR CITY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County		10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1619 Buckeystown Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Child		12b. KIND OF BUSINESS OR INDUSTRY			

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. CITY OR TOWN Frederick		13c. CITY OR TOWN Adamstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1619 Buckeystown Pike, 21710	
14. FATHER'S NAME FIRST Unknown		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Jürgen H. Zimmermann,		ADDRESS 1619 Buckeystown Pk Adamstown, Md. 21711					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 2/21/86	
ACTUAL SIGNATURE <i>Gregory R. Kauffman</i>		EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		23d. LOCATION CITY OR TOWN Monrovia, Frederick, Md.		23e. COUNTY Frederick		23f. STATE Md.	
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home		106 East Church St., Frederick, Md. 21701		25a. DATE REC'D BY REGISTRAR MAR 03 1986		25b. REGISTRAR'S SIGNATURE <i>James H. ...</i>					

DIVISION OF VITAL RECORDS, 201 W. RESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. RESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

NOTICE OF COLLECTION

WINTER

*[Faint, mostly illegible text covering the main body of the page, possibly a form or document with multiple sections.]*